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FINANCING MENTAL HEALTH SERVICES

Perspectives for the 1980s

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service
Alcohol, Drug Abuse, and Mental Health Administration

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Perspectives for the 1980s

Prepared by
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for the
National Institute of Mental Health

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service
Alcohol, Drug Abuse, and Mental Health Administration

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PREFACE

This monograph has been developed to give an overview of some of the financing issues in providing mental health services. The first section of the monograph gives a summary of the funding sources utilized to finance mental health services. Public, federal, state, and local resources are identified. Changing private payment mechanisms are discussed and the public/private interface in funding of a system of services is presented.

The succeeding parts of the monograph cover different perspectives on financing issues. Viewpoints presented include those on historical development, state expenditures, and private payers. In addition, the current social and economic environment for mental health services funding is examined. The last section of the monograph summarizes basic points presented and draws together some conclusions about financing needs and future directions.

Appendices have been developed to serve as a reference for the reader. An inventory of some major federal programs related to mental health services financing has been developed to assist in understanding various funding resources presented. The monograph is meant to share ideas and to give a framework for thinking about needed services, multiple funding sources and furture policy decisions.

M.M. Hastings

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Some sections of the monograph have been developed from selected workshop and plenary sessions given at the Conference on Human Services Financing: State Issues and Options. The Conference was held in San Francisco, April 12-14, 1984 by the National Conference of State Legislatures in cooperation with the NIMH Mental Health Project at NCSL.

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FINANCING MENTAL HEALTH SERVICES: PUTTING THE PIECES TOGETHER

AN INTRODUCTION AND SYSTEMS OVERVIEW

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THIS INITIAL SECTION OF THE MONOGRAPH PRESENTS A SYSTEMS OVERVIEW OF SERVICES, POPULATIONS, AND FUNDING SOURCES AND THE INTERRELATIONSHIP OF PUBLIC/PRIVATE AND FEDERAL, STATE, AND LOCAL FINANCING.

Introduction

This monograph has been developed to provide varying perspectives on the issues currently surrounding the financing of mental health services. Emphasis has been placed on issues from a state decision-making viewpoint. The report is useful in identifying sources of funding and changing funding patterns related to a public/private delivery system of mental health care.

In its first section, this volume takes an overview of financing mental health services from the perspectives of the services needed, the populations to be served, and the principle financing mechanisms currently utilized to provide those services. This section provides a picture of multiple funding sources in the public sector at federal, state and local levels and their interrelationship with rapidly changing private payment mechanisms. It is a systems view and not meant to be an exhaustive presentation of the subject.

The overview introduces themes which are picked up by the individual perspectives that follow in the second monograph section. These selected viewpoints have been summarized from presentations made at the National Conference of State Legislatures' seminar on Financing Human Services: State Issues and Options, held April 12-14, 1984. The major topics covered in those presentations are outlined below.

Historical perspectives are developed in Dr. Howard Goldman's brief history of the shifting responsibility for care of the mentally ill between levels of government and some current changes at the federal level which impact the care of the mentally ill. Further insight into state spending is provided by Dr. Noel Mazade and Dr. Robert Glover who describe a 1984 study which identifies state mental health agency expenditures and revenues.

Moving from public financing to the private sector, Mr. Allen Feezor provides a synopsis of current mental health coverage by private insurance, changes needed in that coverage and key policy decisions for the future. Margaret Kelly follows by describing varying mental health benefits in California. She cites issues which have arisen for the insurer, including qualifications and licensure of a rapidly increasing number and variety of mental health providers. Michael Kipp presents lessons from the private sector. He stresses seven major areas for consideration by state legislators in state policy-making. John Krizay completes the private sector perspective with emphasis on the need to improve current mental health benefit coverage, especially for the seriously mentally ill. He identifies education and public relations as key components in changing benefit coverage.

Financing of mental health services necessarily must be viewed in terms of a larger human service system and society. In the fifth section of the monograph, Dr. Alfred Kahn looks first at new demographic trends which are expanding the demands for human services. Mr. Thomas Gilmore identifies pressures on human services planning in an era of cutbacks and reorganization. Dr. Stanley Wallack examines alternatives in long-term care where there is an accelerating service demand in response to the changing demography. This increased demand must co-exist with the pressing needs both to control costs in human services and provide humane care. Perspectives on financing human services by a state executive, Michael Petit; a county official, Forrest Campbell; and a district court judge, William Jones, emphasize the need for more cooperation between agencies of government. They present examples of successful projects in intergovernmental human services planning and financing.

The final section is a summarization of ideas presented in the monograph. It is followed by some conclusions and future directions. Appendices have been developed to provide additional reference material related to ideas presented in the monograph. Of special interest is an inventory of existing federal laws which provide various funding sources for mental health and related services.

Historical Perspectives on Financing

The financing of mental health services in the U.S. represents an evolution which has occurred over 200 years. This evolution generally reflects changing public attitudes; shifting responsibilities for care of the mentally ill; and changing modalities in treatment. Research findings in brain functioning and other biomedical areas have influenced substantially financing directions. The shifting responsibility and related funding patterns for care of the mentally ill can be seen in a brief history of mental health services financing in the United States.

The development of public responsibility for the mentally ill can be divided into three phases. First, those with mental illness were a responsibility of the local community from colonial times until the mid-nineteenth century. Care for the mentally ill was given by local charity, church groups, admissions to the very few existing general hospitals (New York, Boston and Philadelphia) and, often, by police and in jails (Klerman, 1979).

Second, responsibility shifted to the states in the Jacksonian era as state legislatures established needed facilities and the advocacy efforts of Dorothea Dix became successful. By 1900, one or more large hospitals existed in every state and territory. Various efforts at trying to change these conditions or modes of custodial care were unsuccessful, and even in 1950, 80% of all care for mental illness was in public institutions.

Third, the major change came after World War II when reform advocacy efforts interfaced with draft experiences during the war. The federal government began to assume responsibility for the mentally ill. A mandate for research and training was passed and the National Institute of Mental Health (NIMH) was created in 1948. Many significant changes followed with the report of the national Joint Commission on Mental Health in 1955. Further developments occurred with President Kennedy's national leadership related to development of community services for retarded and mentally ill. Inauguration of the community mental health centers was seen as an alternative to care in large public institutions. This national effort was paralleled in the 1960's by the development in the private sector of general hospital psychiatric units and private insurance reimbursement, mainly for inpatient care.

The major effort at deinstitutionalization during the 1960's and 1970's rapidly lowered state hospital bed capacities from a peak nationally in 1955 of 559,000 to 138,000 by 1975. Many new benefits and financing mechanisms emerged in the 1960's to support this movement to the community. This has resulted today in a series of critical policy questions. These are directed at defining those persons who will receive public benefits and, then, determining the scope and shape of private benefit, third party options (Merwin and Ochberg, 1983).

Mental health financing can be viewed from three basic perspectives: the populations to be served, the services to be provided and the financing mechanisms used to render those services.

Defining the Service System

As mental health treatment has evolved, basic services needed for care and treatment have been identified. These services were first delineated in federal policy with legislation for the comprehensive community mental health centers in 1963. This act was a direct response to President Kennedy's address to Congress, February 5, 1963 which asked for a "national mental health program to assist in the inauguration of a wholly new emphasis and approach to care for the mentally ill" (President's Commission, 1978).

Private or public non-profit agencies receiving money under this act had to present a plan for a coordinated program of at least five essential mental health services: inpatient, emergency, partial hospitalization (such as day care), outpatient, and consultation and education. There were other services recommended but not required. These included specialized diagnostic services, rehabilitation, preadmission and post-discharge services for state hospital patients, research and evaluation programs, and training and education activities.

In 1975, after considerably greater experience with the wide range of services needed in the community, amendments were made to the original community mental health center act. The amendments called for the provision of the five essential services (as above) plus specialized services. This set of additional services focused on: children and elderly; assistance to courts and other public agencies in pre-admission screening for state hospitals; and followup care for those discharged from state hospitals. Halfway houses, programs for alcoholism and drug abuse, and public education and consultation activities with a wide range of social institutions also were included in the 1975 amendments.

This wide array of services reflected the changes in the delivery system to accommodate the course of treatment for seriously mentally ill. This legislation recognized the existence of and need for coordination with other service agencies that came in contact with the care of mentally ill persons. The importance of preventive efforts through public education and consultation activities also were identified.

As community services grew, state mental health statutes were developed. They required specified services which also define the basic community delivery system. As an example, *The Illinois Revised Statutes* (1983) define basic services in the *Community Services Act*.

It states that community services should be planned, developed, delivered and evaluated as part of a comprehensive and coordinated system. The state mental health authority is designated to oversee that establishment. The service categories in the legislation are prevention; client assessment and diagnosis; crisis and emergency; treatment, habilitation and support; community residential alternatives to institutional settings; and case coordination.

With the advent of a national health planning law in 1975, communities began to define essential services to be made available within the geographic area of each Health Systems Agency. The Health Planning Law itself (P.L. 93-641) delineated a system of services and emphasized planning for each of those components in a given geographic health service area. Such a chart of generic services is defined by one HSA as part of its mental health plan (HSA Suburban, 1982).

This health planning service matrix reflects similar categorization to the state and federal acts with generic essential service functions: primary prevention; consumer identification and assessment; crisis stabilization and emergency; growth and habilitation; maintenance; and case management. An addition in the HSA service system is the recognition of intensity of services within each of the basic categories indicating natural, supportive, and protective settings (See Appendix D).

Many reasons exist for developing a full range of services as evidenced in state and federal law. First, there are varying levels of client need. Individuals may need intensive treatment, but as conditions stabilize and improve, individuals move to less restrictive services and gradually begin activities in more normalized environments. Others may have need only for brief intervention through individual or group outpatient programs.

Second, as has been seen in the history of mental health treatment, funding only one piece of the service system leads to inappropriate utilization of that piece. Historically, often the intensive treatment (or restrictive custodial care) was the only service available regardless of individual client need, level of functioning, or prognosis. The treatment setting itself could then lead to the worsening of the patient's condition and impede ability to return to the community.

Recognition, then, of a need to finance a system of services for a range of populations becomes critical to understanding the patchwork of financing mechanisms which are utilized today.

Involved in this more integrated set of services is the changing role of the state hospital. As more persons are treated in the community, state hospital bed capacities have been drastically reduced. This leaves a remaining number of beds which should supply a defined set of services as part of an integrated system. Because of the severity and type of persons served at state hospitals, these state beds are very costly to operate, if physical plants, adequate staffing, and programmatic components are to be maintained. Increasingly, state hospitals are treating three groups of mentally disabled: the multiply handicapped, the very difficult to manage, and the court adjudicated person. This last group includes the unfit to stand trial, not guilty by reason of insanity (NGRI) and those remanded to the mental health system in lieu of jail or prison (Illinois Commission on Mental Health, 1982). These numbers requiring secure settings are expected to grow and will demand more specialized forensic programs.

With the dramatic reduction in state hospital beds there has been an accompanying rise in the number of chronically mentally ill persons served in nursing homes. This has been referred to as "trans-institutionalization". Of the estimated 900,000 (National Plan, 1980) institutionalized chronically mentally ill, 750,000 are in nursing homes and 150,000 in state hospitals.

The availability of federal programs to pay for services to sick or disabled has had a "profound impact" (National Plan, 1980) on the locus of care of the chronically mentally ill. For example, between 1969 and 1973, the number of persons 65 or over with psychiatric diagnoses in nursing homes grew from 96,415 to 193,900. During this same period, the identical group declined substantially in state hospitals.

During the 1960's and 1970's nursing homes began to serve some of the functions and populations of the state hospitals. Federal financial incentives have encouraged this shift. States used these new payment systems to have the Federal government share in costs which, previously, had been state and local responsibility. This is discussed further in the federal financing section of this overview.

In 1980 (National Plan) nursing homes were identified as the single largest provider of services to chronically mentally ill. With this service phenomena, serious attendant problems in service delivery have developed. Problems include mixing of frail physically ill with mentally ill ambulatory persons, inappropriate or non-existent programming, facility size, reimbursement rates, and accountability for the mentally ill. Restrictive federal payment policies discouraged appropriate mental disability diagnosis and related development of rehabilitative programming. Linkages to physician medication consultation and the specialty mental health sector have been limited for those mentally ill (18 to 64 years of age) in nursing homes.

It is evident from the discussion of the wide range of mental health services needed to plan for a total geographical area that there are different types of mental health problems and levels of care needed. Understanding of those populations and their varying levels of need is presented in the next section.

Defining the Population

Defining populations in order to plan for mental health care has been an ongoing dilemma. The President's Commission on Mental Health (1978) indicated that approximately 15% of the population at any one time was in need of some type of mental health care. Population rates for mental illness conditions have been estimated by a number of studies in Europe, Canada, and the United States.

The consumers of mental health services can be divided into groups, generally related to the degree of disability or dysfunction. Anywhere from 5 to 15% of the population may suffer at any one time from a wide range of problems, from mild anxiety to severe psychosis. Prevalence rates vary, but are thought to be about .5% to 3% for schizophrenia, .3% for manic depressive psychosis, 7% for personality disorder, and 8 to 13% for neurosis including depression (Dohrenwend et al., 1978). The lower and higher figures for schizophrenia and neurosis reflect utilization of different definitions (President's Commission, 1978).

National Population Needs. In looking at the national scope of the problem, statistics (Economic Fact Book, 1983) indicate that in any one year 31 to 41 million Americans suffer from a diagnosable mental disorder involving some degree of diminished capacity in employment, school or independent living. Six million children are estimated to have serious mental disorders that impede developmental processes necessary for normal maturation and a productive adulthood.

The growing elderly population, due to the aging processes, are more vulnerable to mental disorders, especially depression. Twenty-five percent may have serious mental disorders.

Four million Americans are at risk for schizophrenia, a chronic mental illness accounting for an estimated 70% of mental hospital admissions. Eight to 14 million Americans each year are afflicted with depression and manic-depressive illness.

In the U.S., 20% of those who seek medical care have disabling anxiety disorders and 54% of persons with significant mental disorders are cared for in the general health care setting, not in the specialty mental health sector.

There is recognition that mental illness problems are not seen in isolation but often coexist with other conditions, such as alcohol and drug abuse, mental retardation, severe hearing impairments and other handicaps, and major diseases.

A New Look at Prevalence. There have been a variety of attempts to define populations more specifically in order to estimate levels of needed service. A landmark epidemiological study by the National Institute of Mental Health (Regier et al, 1984) recently released preliminary results on findings in three geographic areas studied for prevalence of DSM III (see glossary) disorders identified through a Diagnostic Interview Survey.

The preliminary results show 17% to 23% of adults have at least one mental disorder. Lifetime rates, in the new NIMH prevalence study, for fifteen DSM III psychiatric diagnoses indicate that the most common diagnoses are alcohol abuse and dependence, phobias, major depressive episodes and drug abuse and dependence. Substance abuse accounted for 7%; affective disorders, 6%; anxiety, phobias, and other somatic disorders, 8%; and schizophrenia, 1% (Robins et al, 1984). Institutionalized populations are not included in the study results.

When all disorders were counted, men and women showed similar overall prevalence rates but differed in types of disorder. Disorders that most clearly predominate in men were antisocial personality and alcohol abuse and dependence. For women, depressive episodes and phobias were most common (Robins et al, 1984).

Overall, the study indicates a low percentage (20%) of those identified in the study with disorders were actually treated. Schizophrenia showed the highest rate of treatment contact (about 50%) over a six-month period (Freedman, 1984). Types and rates of mental disorders were also seen as affected by a variety of factors including age, sex, education and urbanization (Robins et al, 1984). Higher rates of disorder were associated with the inner city environment. More common in the inner city were drug and alcohol abuse, antisocial behavior, and schizophrenia.

Populations and Levels of Care. Three basic groups seeking mental health care based on degree of disability, have been defined (Merwin and Ochberg, 1983). The first group are those using public or private outpatient services for moderate depression, anxiety, emotional and other problems related to family, poor role performance, and substance abuse problems. They receive care from natural support such as clergy, family service agencies, women's centers, etc. Financing for these services usually comes from client fees, charitable donations and United Ways, government grants and/or some type of insurance. These consumers are not seen as mentally ill.

A second group has been defined as persons "at risk" of developing more serious problems, these problems may be results of extreme stress, from chronic illness, job requirements, victimization, long-term unemployment, etc. Services sought for these persons must be substantive as well as supportive, including vocational retraining, job counselling, stress management, etc. Many of the range of services needed would not be covered by private or public third-party health insurance.

A third group of consumers is composed of a wide range of dysfunctional persons seen as mentally ill. Common characteristics of these persons can be found often in their marginal lifestyle, poverty and lack of social supports, dependence on public funding organizations and minimal basic social and living skills. They are most frequently identified as being schizophrenics, manic-depressives or having personality disorders.

Chronically Mentally Ill. In the 1970's major concern emerged over this third group, the chronically mentally ill (Talbott, 1981), many of whom had been deinstitutionalized and lived marginally in the community.

The chronically mentally ill (see Glossary, Appendix B) have been variously defined. They have psychiatric disorders which erode or prevent the development of their functional capacities and have problems even with basic daily living chores. Many chronically mentally ill persons have required extended and/or frequent institutional care and have difficulty with basic economic self-sufficiency. The deinstitutionalization of large numbers over the past thirty years was seen as humane. For many, it was a chance, with much assistance, to lead a more normal life. However, others were "dumped" without adequate planning or services. They met with an unwelcome community environment. Many have become today's homeless,instigating discussions of reopening state hospitals or creating safe asylums as alternatives to crowded temporary shelters.

Deinstitutionalization policy, born in the 1960's, crystallized when various forces joined together, including human rights groups, psycho-social rehabilitation treatment advocates, and pharmacological advances. Economic pressures came from state capitols to shift costs of some programs to new federal Medicaid, Medicare, and supplementary security and disability entitlement programs. This major restructuring of the delivery system has become both pluralistic and voluntaristic in the options and payment schemes for mentally ill persons (Klerman, 1977).

Some of the failures of deinstitutionalization have related to funding and program delivery. Heterogeneity (Bachrach, 1982) of the original "target population" has created a need for highly diversified programming. Existing funding structures do not lend themselves to providing continuity or comprehensive care to chronic patients. And, finally there has been a general failure to engage society in deinstitutionalization efforts and stigma continues to be heightened by poor press related to street people.

In recent years initial excitement about deinstitutionalization has evolved into concern about specific population groups for whom deinstitutionalization planning was not done or was not effective. This has led to a whole new set of problems. Numerous authors have looked at deinstitutionalization failures and successes.

One of its successes has been development nationwide of the National Institute of Mental Health's Community Support Program (CSP) (NIMH, 1982) which is a program that provides for case management and coordination of a full range of support services to chronically mentally ill living in the community. It follows the concept that a full set of treatment, habilitation, social, recreational, housing and other support services are necessary for chronically mentally ill persons to make the transition successfully to the community setting. However, there is not nearly enough CSP capacity to deal with the large numbers needing the service and some populations have been unresponsive even to its offerings.

Special Populations and Needed Services Financing

A further look at chronically mentally ill persons has led to identification of specific populations that need substantially differentiated care and related funding. These include the young adult chronic population (Bachrach, 1982, 1984), the homeless (Jones, 1983), the elderly (Zarit, 1980) and children and adolescents (Knitzer, 1982).

Children and Adolescents. Financing appropriate services for mentally ill children has been a continuing national concern (Knitzer, 1982). Capacity of the system to provide longer term residential and special day treatment settings following crisis or acute care has been lacking. Special education has evolved as a major financial source for some of these programs.

A recent report of the U.S. Department of Education (1983) identifies the numbers of those children receiving special education and related services. Emotionally disturbed children identified and served went from 283,072 in 1976-77 to 341,786 in 1981-82.

However, estimates of emotionally disturbed and mentally ill children in the United States range from 3 to 6 million. An uncertain estimate is symptomatic of the complexity of the subject and lack of planning on a unified basis to deal with the problem.

About two percent of all children under 18 years receive some type of mental health or related services. Based on conservative estimates, then, two-thirds of seriously disturbed children and adolescents probably do not receive appropriate care. The most disturbed are often least likely to receive help (Knitzer, 1983).

The failure to provide these services has been documented well over the last fifteen years (Joint Commission on Mental Health, 1970; President's Commission, 1978; Knitzer, 1982). With the new focus on the complexities of serving the young adult chronic (YACP), it must be noted that many of those individuals are the inadequately-served child and adolescent of a few years ago.

These youth exist in several state systems, including mental health, juvenile justice, child welfare, substance abuse, child abuse and neglect as well as education. Service delivery problems are reflected in the recently reported shortage of trained teachers for disturbed youth in 34 of 48 states.

However, education is just one component of a more comprehensive program of support needed for these multi-problem children and their families. States need at minimum to focus both on planning and interagency coordination for these children and on developing capacity in the service delivery system for a full range of services. These include comprehensive clinical diagnostic assessment, crisis and emergency, intensive treatment, long-term and transitional residential care, and a community support program for maintenance of stability in the community.

In recognition of the three million estimated seriously emotionally disturbed children (two-thirds of whom are receiving few, inappropriate, or no services) NIMH established the Child and Adolescent Service System Program (CASSP). This program provides grants to states toward development of the continuum of care that is needed by emotionally disturbed youth. In addition to mental health services, this population requires services from a variety of different agencies and systems which typically are fragmented and uncoordinated (Isaacs, 1984). Initiated in 1983, ten states have CASSP grants in 1984 with plans to expand the program.

One agency or designated authority must take the lead in developing a full range of services to deal with the multiple types of problems and levels of functioning within this group of youth. However, multiple funding sources must be utilized to meet the challenge. Also states should make every attempt to allocate funding to earlier identification and systematic intervention so as to diminish need for expensive residential treatment programs. In the later teen years, positive prognosis is limited and treatment expense is highest.

All states have reported difficulties in meeting the needs of emotionally disturbed youth. In a recent survey, states that were making significant progress on the issue were identified. They had in common key elements essential to any state program for emotionally disturbed youth: sustained commitment over a long period of time; strong support from legislative and executive branches of state government; carefully defined and documented target populations and program philosophy; implementation focused at the local level; and redirected and/or additional funding (Isaacs, 1984).

Lack of cross-agency planning, confused state statutory responsibility as well as missing service system components have led to major problems in delivery of care to emotionally disturbed and mentally ill children. This lack of investment often indicates later payment for these same children as chronically ill adults in state mental institutions, jails, prisons, and in the welfare system.

Young Adult Chronic. The young adult chronic (YACP) has been variously defined recently as a subpopulation of specific concern to states in the financing of services (Bachrach, 1984). This group is seen as the major new population in state hospitals and accounting, in part, for a very recent increase in need for state hospital beds after a long period of state bed reduction.

The YACP has been described as a variable group, some passive and apathetic, but most are treatment resistant, often have substance abuse problems, visit emergency rooms constantly, have few stable relationships, and present episodes of serious behavior problems. They cause high rates of staff burnout, can be manipulative, and make inappropriate but persistent patterns of service demand. Housing is the most critical and difficult service to provide. Many become part of the "homeless" group identified and described in many recent studies.

Identifying the Homeless. The homeless appear to be a variety of persons who have been described as the most "desparate subgroup of the disenfranchised" in our society. Estimates of their numbers nationally vary from 250,000 to 3 million. It is believed that at least 25% to 50% of these homeless suffer from chronic, serious mental illness.

Several studies in recent years in New York, Philadelphia and other metropolitan areas have attempted to make profiles of the homeless, usually those found in urban shelters. Their characteristics appear to vary among the shelters surveyed, but certain common themes emerge. The homeless are predominantly male and many have a history of psychiatric hospitalization in state facilities. The most prominent diagnosis is schizophrenia. Many of the homeless were state hospital patients in the mid '60's and '70's with short stays while others are young with mental illness, but with no history of state hospitalization.

Social deficits and inability to tolerate frustration or deal with stress are characteristic of their mental illness. Lack of an address and other connections to society leads to deprivation of welfare checks and the utilization of the most basic community resources.

The increasing numbers of homeless are seen as results of deinstitutionalization policies, economic recession, unemployment, federal cutbacks in support services, and lack of low cost housing. In order to address the problem, some agency of state or local government must take the lead. Financing of basic survival needs of shelter and food must be addressed before outreach rehabilitation efforts can begin. Steps must be taken to provide adequate services in the community: provide a full range of residential placements, aggressive case management, and the structure that some chronic patients need to prevent criminalization as an option that replaces care and treatment.

Aging and Mental Disorders. The rapid rise of the aging population and the longer life span bring increased vulnerability for mental health problems. Many of these problems are treatable and, when treated, advance the quality of life for the individual and his or her family. There are currently 25.5 million older persons making up over 11% of the population. Life expectancy has risen to 77.2 years for females and 69.5 years for males. In 1900 only 2% of the population was 65 years or older and the average life expectancy was 47.3 years. As a result, there are new demands on the mental health system for care of a growing aging population which will increase to 35 million by 2000.

Mental illness is more prevalent in the elderly than in younger adults. An estimated 15 to 25% of older persons have significant mental health problems. Yet only 4% of patients are seen at public outpatient mental health clinics. Two percent of those seen in private psychiatric care are elderly (President's Commission, 1978). Medicare coverage discriminates against mental illness conditions in inpatient and, substantially, in outpatient service coverage.

Depression, alcohol and drug abuse are major problems among the aging; 25% of all reported suicides are committed by elderly persons. Alzheimer's disease, a leading cause of mental deterioration among the elderly, affects 5%

to 10% of all people over 65 years. Alzheimer's victims constitute a high percentage of the 1.3 million in nursing homes.

Programs of respite care, day care activities, and home support services must be developed if institutionalization of aging persons with more serious mental conditions is to be prevented. Mental health, aging, medical, and social service programs must coordinate in solving these problems.

Currently there are substantial barriers to mental health treatment for the aging. These include lack of appropriate programs and trained medical and mental health personnel; lack of state policies toward development of programs; and poor third party coverage for services. There is a need for outreach to elderly to counteract distrust, low self esteem, and beliefs that the conditions they have can not be helped (Tolliver, 1983).

Women's Needs. Women have special needs within the mental health system. Women are overrepresented among the mentally ill (President's Commission, 1978) and are more often hospitalized for depression than men. Depression is more common in women than men and rates of unipolar depression are about twice as high. Biological findings related to neurochemical, endocrinological, and sex-linked genetic factors are being studied as well as psychosocial factors (lower status, learned dependency, etc.) for roots of this phenomena. Eighty percent of amphetamines and more than 60% of tranquilizers and sedatives are prescribed for women leading to prescription drug dependencies and inappropriate treatment regimens. An estimated five million women are alcoholic, but a small percentage actually receive treatment. Anxiety disorders are more often diagnosed in women with excessive fears and somatic complaints occurring more often than with men. Another area with unusually high incidence in women is anorexia nervosa, 95% of the cases being females between 12 and 18 years old.

Other special mental health service needs of women relate to victimization in family violence and early life sexual abuse, the stress of single parenthood, and low economic status. Rape has profound emotional impact, is dramatically under-reported, and fear of rape restricts lives of many women. Sexual abuse is linked to later life mental health and substance abuse problems.

Women are more likely to be financially dependent, have children, be underemployed or unemployed leading to greater barriers in accessing treatment, especially through limited availability of private third-party reimbursement. Their success in accessing treatment services often is related to need of other ancillary services such as child care, vocational training, and job placement.

Sex segregation and stratification characterize much of the mental health delivery system leading to treatment emphases which may be inappropriate and to lack of policy initiatives to develop more effective programming for women. Nontraditional service delivery programs for women and by women and self help groups are beginning to meet some of these needs (President's Commission, 1978).

Although many needs of women have received much attention in the mental health system, there are other subgroups for which there is little: women in prisons, certain ethnic and racial minorities, and, as previously mentioned, the aged.

Minority Groups and Mental Health Services. Special planning and funding must be addressed for minority services. Even though there are major differences between and among Black, Hispanic, Asian, and American Indian groups, certain major concerns need to be addressed for each of these groups.

In general, funding should go to mental health services which are geographically and economically accessible. Utilization and effectiveness of those services are related to the personnel who staff them. These persons should respect and understand the unique perspective and value systems of those being served. Minority populations in the mental health disciplines are in short supply. Active recruitment of minority group members, training, and more meaningful curricula in the training process are needed for minority service provision. Appropriate data gathering on specific minority populations and related services research are essential to allocating funding and strengthening the services delivered (President's Commission, 1978).

Financing Forensic Services. Funding for the forensic population is a growing challenge for most state mental health agencies. These populations in the mental health system who are sent by the courts, usually come for two reasons. They have been found *not guilty by reason of insanity* (NGRI) or they are *unfit to stand trial* (UST). According to recent estimates these populations are growing as a percentage of state mental hospital populations. Their security needs as well as emphasis of the UST's on becoming "fit" are believed to place increased burdens on staffing and program management in the public treatment system.

The forensic cases are based on certain legal foundations, including the right to testify, to present evidence and confront adverse witnesses (Herr et al, 1983). These procedures are ineffective if the defendant is incapable of exercising them. A finding of incompetence excuses one from trial but does not relieve the charges. When competency is achieved, the trial proceeds.

The basis for incompetency is that the defendant is unable to understand the proceedings or charges against him or her and is unable to cooperate with counsel and assist in his own defense. A defendant must be found incompetent through a competency evaluation at which point he or she is committed to treatment to become fit. This is when the mental health system takes over for an indefinite period and must provide secure treatment settings.

In *Jackson vs. Indiana*, the Supreme Court ruled that defendants found incompetent to stand trial could not be held indefinitely in a mental health facility and such commitments must be justified by treatment progress. This has led to states setting specific time limits on treatment after which release occurs. With the last decade's more stringent commitment laws, some believe that UST's are increasing as a way to obtain an inpatient treatment setting not available through other means.

Although often confused when discussing forensic services, incompetency is different than a defense of not guilty by reason of insanity (NGRI) which, if proven, results in acquittal. At the time of acquittal, a civil commitment procedure can then be entertained. Although civil commitment procedures have been maintained for NGRI's, some well publicized cases of extreme incidents have led in some states to special release and discharge decisions. These are reviewable in appropriate cases by a court with safeguards for the person and the public. Released NGRI's are often followed up with specific outpatient services. Both inpatient and outpatient expenditures for the NGRI are part of state budgeting for mental health services.

However, states vary in many specific ways in handling the insanity defense due to the differences in definitions of insanity, the responsibility for burden of proof, and the availability of a newer verdict of guilty, but mentally ill (GMI). GMI's are often sent to the mental health system for treatment but may be returned to the correctional system to finish a sentence. Eight states have GMI provisions in the law (Report to the Nation, 1983).

The largest group of convicted or accused persons needing special services planning and financing in the mental health system are drawn from the prison population. In 1978 prison inmates made up 54% of the convicted or accused who gained admission to mental health facilities. The NGRI admissions (only 8%) were a large portion (22%) of the average daily census due to extended length of stay (Report to the Nation, 1983). The incompetent-to-stand-trial group constituted 34% of forensic admissions and 24% of daily census. The mentally disorderd sex offender accounted for 6% of forensic admissions and 17% of the forensic daily census. To underscore the cost and scope of forensic services in mental health facilities, in 1978 a total of 20,143 forensic patients were admitted to mental health facilities with an average daily census of 14,140 (Steadman, 1982).

Increasingly local and state departments of corrections are needing to provide mental health services to mentally ill offenders. These program services require substantial expertise. They may be provided by qualified professional facility staff, by separate psychiatric correctional facilities, by contract to outside providers, or, under certain conditions, by transfer to the mental health system. With the increased pressure on admissions in every state to the correctional system, allocation of funding for diagnostic, treatment, and habilitation services for the mentally ill in corrections has been a lower priority.

Funding Sources for Mental Health Services

After defining rates of disability, the dilemma in planning and financing mental health services is translating those figures into how much of what services should be developed for maximizing efficiency, effectiveness and humane care at the community level. The heterogeneity of the populations and the long-term needs of more severe mental illness have led to multiple funding systems within the specialty mental health sectors and within funding for generic health, welfare, social services, disability, housing, and food programs.

Numerous funding sources have sprung up in attempts to finance a system of services; to respond to the varying intensity of client needs and disability; and to accommodate special populations. Historically, funding responsibilities have shifted between levels of government and between the public and private sectors.

These funding sources can be categorized first as public dollars from federal, state, and local tax sources. Private sector dollars come principally from patient fees and from third-party payers and charitable donations.

In 1971 estimates indicated that 35% of all mental health expenditures were paid by consumers individually; 31% paid by state and local dollars; 21% paid by federal dollars; and 11% by private insurance (President's Commission, 1978). These percentages have changed as private insurance payments have expanded and as federal program requirements have changed. In mental health expenditures nursing homes account for approximately 30% of total dollars and state public mental hospitals account for 23% of total mental health expenditures (Gibson and Waldo, 1981). The nursing home figures are representative of the shifts of patients and costs during deinstitutionalization from the state to federal/state payment systems with Medicaid dollars paying a substantial portion of the nursing home bill. It is estimated that as many as 44% of the chronically mentally ill are now cared for in nursing homes while 12% are in state and county mental hospitals.

In looking at the national total expenditures for personal health care, mental disorders were found to be third in overall spending, ranking behind diseases of the circulatory and digestive systems (Hodgson and Kopstein, 1984). When these personal health care expenditures were analyzed by age and sex, mental disorder expenditures ranked third for males and fourth for females under 65 years. However, in the over 65 year category, mental disorders ranked fifth for males and second for females. This last finding reflects the greater longevity for females and the increased vulnerability of the aging to mental disorders. It indicates the high percentage of serious mental disorders among the aging that are cared for in expensive insitutional settings.

Among males under and over 65 years, the largest personal health care expense for mental disorders was in hospital care. For women under 65 years, the largest expense also was for hospital care; but for those females over 65 years, the largest expenditure was for nursing home care.

More recently, in 1980, the payment sources for personal mental health expenditures in the United States have been identified as 25% from federal sources; 35% from private sources; 28% from state and local sources; and 12% from insurance on a total mental health revenue base of $30.5 billion. Personal mental health care in 1980 represented 14% of the national medical expenditures (Economic Fact Book, 1983). Sixty-three percent of that mental health total was for institutional care (Health United States, 1983).

Federal Financing for Mental Health and Related Services

The major federal legislation creating programs for financing mental health care and related services has been summarized in Appendix C. Each program is listed with its statutory cite, major purpose and basic provisions, funding, eligibility, and brief legislative history. The reader should refer to this basic, comprehensive resource to understand the programs which are mentioned in this section.

A large number of federal programs provide various funding resources for different pieces of the needed service system. A review of these programs is critical to understanding the diffused responsibility and fragmented system which has developed in the "post-institutional era."

Entitlement and Categorical Programs. The largest amount of federal funding for mental disability comes through entitlements: Medicare, Medicaid, Supplementary Security Income (SSI), Social Security Disability Insurance (SSDI), and Veterans Administration Benefit Programs. In FY 1985 the total appropriations nationwide for these five programs will be in excess of $120 billion.

Further examination of entitlements indicates that they exist in principally two forms: entitlements for specific services to eligible persons (Medicaid, Medicare, Veterans Benefits and Special Education) and entitlements to individuals for income for basic needs (SSI, SSDI). There are also hybrids of these entitlements, such as the Veterans Administration which gives medical services to entitled persons and also provides disability income to support individuals.

Medicare was enacted in 1965 as Title XVIII of the Social Security Act and became operational July 1, 1966 with 19.1 million aged enrollees. It is a federally administered and financed program for health services. It covers hospital, physicians' and other medical services for most persons 65 years or over, disabled persons entitled to social security cash benefits for 24 months, and most persons with end-stage renal disease. It requires various co-payments in both parts of its program.

Medicare has two complimentary but distinct parts: Hospital Insurance (HI) called Part A; and supplementary medical insurance (SMI) is known as Part B. About 95% of the U.S. 65 year olds and over are in the Part A program. On July 1, 1981 there were 29 million aged and disabled enrollees (Medicare and Medicaid Data, 1983).

For general health benefits the Hospital Insurance (HI), Part A, program covers 90 days of inpatient hospital care per episode of illness with no limit to the number of benefit periods in a lifetime. The program also provides a life-time reserve of 60 days if the 90 days per benefit period are exhausted. In addition, the HI program covers up to 100 post hospital days in an skilled nursing facility, if appropriate certification for that service is obtained. Some home health benefits are also covered under HI.

Most persons covered by HI elect to enroll in Part B which requires a small monthly premium. Under a "buy in" arrangement, most state Medicaid programs pay these premiums for persons who qualify for both Medicaid and Medicare. Part B covers physician payments, outpatient hospital services, rural health clinic and home health visits. There are several areas not covered by Medicare including drugs, dental and eye care, and preventive services; and, frequently with most concern, there is no nursing home (ICF) long-term coverage provided.

A summary of distribution of reimbursements across basic service categories indicates the acute care, institutional emphasis in Medicare. The 1980 Amendments removed some limitations on home health care utilization and expanded outpatient surgical coverage. Some changes in percentage distribution in service categories are anticipated as a result. The consistency of institutional spending over several years is illustrated in the table below.

PERCENTAGE DISTRIBUTION OF MEDICARE
REIMBURSEMENTS BY TYPE OF SERVICE
CALENDAR YEARS 1967 AND 1980

	1967	1980
Inpatient	62.7%	66.4%
Outpatient	.9%	5.8%
Home Health Agency	1.9%	1.9%
Skilled Nursing Facility	6.5%	1.0%
Physicians' and Other Medical Services	28.9%	24.9%

Source: Medicaid and Medicare Data Book, 1983

Medicare is a $65 billion national program; yet a small percentage of those resources goes to mental health care despite the rapidly increasing mental health service demands among the aging. Limits for mental illness coverage are restricted to 190 days lifetime inpatient care in a psychiaric facility. There is also a limit of $250 per year maximum for outpatient services. Outpatient also requires a co-payment. In 1975, mental health coverage comprised about 2% of Part A expenditures and was less than 1% of

Part B reimbursement (PCMH, 1978). Such expenditures reflect little care and encourage hospitalization. Although inpatient psychiatric services are exempt temporarily from Medicare DRG's, it is anticipated that the prospective payment system, when implemented, will further limit mental health inpatient benefits.

Medicaid was enacted in 1965 as Title XIX of the Social Security Act. Although it is a federally assisted health care insurance program, it differs substantially from Medicare in design, funding provisions, scope of service inclusions, and eligibility requirements. Medicaid is a federally supported and state supported and administered assistance program. It provides medical benefits to certain low income individuals and families.

The program provides medical assistance to those persons who are eligible to receive cash payments under Aid to Families with Dependent Children (AFDC) and Supplemental Security Income (SSI) for aged, blind and disabled. Each state administers program eligibility differently; each state has the option of providing services to the "medically needy", persons whose incomes fall below certain levels but are not eligible to receive cash assistance.

DISTRIBUTION OF MEDICAID RECIPIENTS
AND PAYMENTS BY ELIGIBILITY, FISCAL YEAR 1980

Basis of Eligibility	% of Recipients	% of Payments
Aged	15.8%	37.3%
Blind	.4%	.6%
Disabled	12.6%	30.1%
AFDC	65.1% (adults 22.1%) (children 43%)	28.1% (adults 14.5%) (children 13.6%)
Other	7.0%	3.9%

Source: Medicaid and Medicare Data Book,, 1983

The Medicaid program requires that states offer a set of basic services to all recipients: inpatient, outpatient hospital services, laboratory and x-ray, skilled nursing facilities (SNF) for 21 years and over, home health services for SNF eligible persons, physician services, family planning, rural health clinic, and early and periodic screening, diagnostics, and treatment services for individuals under 21 years of age.

States may choose to cover a variety of other services, such as drugs, eyeglasses, intermediate care facilities, physical therapy and dental care.

Medicaid is a program that pays providers for services to eligible persons, and the participating providers must accept Medicaid reimbursement as payment in full. Co-payments may be required on some services.

MEDICAID PAYMENT BY SERVICE DISTRIBUTION
FISCAL YEARS 1973 AND 1980

Service	Fiscal Year 1973 Percent	Fiscal Year 1980 Percent
Inpatient	30.8%	26.9%
Outpatient	3.1%	4.7%
Physicians'	10.7%	8.0%
Nursing Homes	34.9%	42.5% (26.6% ICF) (15.9% SNF)
Other	20.5%	17.9%

SOURCE: Medicaid and Medicare Data Book 1983

Medicaid is jointly financed by federal and state revenues with states being reimbursed from 50% to 78% for reimbursable services provided to eligible persons. Medicaid is both an acute care and long-term care payment program. In 1981, through the Omnibus Reconciliation Act, a Medicaid waiver for home and community based services was offered to states to fund a variety of community services as an option to those who would need institutional care, such as the mentally ill and aging.

The waiver has provided an alternative to the institutional benefit bias in Medicaid. Almost 70% of expenditures in 1980 were for institution based care. Nationwide Medicaid reimbursements in 1980 were composed of 27% for inpatient hospital, 26% for intermediate care and 15% for skilled nursing facilities (Medicare and Medicaid Data Book, 1983). Since 1973 an increasing percentage of Medicaid has been spent on long-term care.

It is estimated that $4.1 billion was spent nationally for Medicaid mental health services in 1977, thereby making Medicaid the largest single mental health program in the country (PCMH, 1978). Nursing home payments for the mentally disabled may comprise as much as 40% of the Medicaid nursing home expenditure (President's Commission, 1978).

Medicaid provides financing for a variety of mental health services, both mandatory and optional. These must be made available to the mentally ill on the same basis as for other persons receiving Medicaid Services. This nondiscriminatory provision has led to difficulty in securing utilization data on mental health services under Medicaid. This non-discriminatory provision on the basis of diagnosis is superseded by specific provisions in the law that exclude reimbursements to individuals in Institutions for Mental Disease who are 22 to 64 years old.

One of the more challenging Medicaid provisions for states relates to Institutions of Mental Disease (IMD). A psychiatric hospital, state mental hospital, or nursing home in which more than 50% of residents are diagnosed with primary mental disorder is considered an IMD. Reimbursement under Medicaid will not be provided for mentally ill individuals 22 to 64 years of age who are in IMD's. Medicaid institutional reimbursements for non-aged mentally ill adults are limited to inpatient services in general hospitals, or to nursing homes that are not IMD's.

Mandatory mental health benefits under Medicaid (Toff, 1984b) include inpatient services in the psychiatric unit of a general hospital, outpatient hospital services, physician services, and skilled nursing facility (SNF) services for those over 21 years.

States may include optional mental health services: inpatient care for 65 and over in an IMD and for those age 21 and under; clinic services (free-standing); day care, night care, and partial hospitalization; non-IMD intermediate care and skilled nursing facilities; ICF services in IMD for 65 years and over; and services rendered by clinical psychologists and psychiatric social workers under certain conditions.

Within both mandatory and optional services, states are free to set limits on amounts and scope of coverage leading to very uneven services nationwide. Since states are given a great deal of flexibility in administration, the mental health benefit program varies significantly from state to state. Even with mandatory services states can establish scope and duration limitations.

To illustrate this point, a recent 50-state Medicaid mental health survey (Toff, 1984b) noted that eight states limit psychiatric outpatient services; and nine states limit the number or type of psychiatric visits under physician services 21 states provide direct reimbursement to psychologists, while one state provides direct reimbursement to nurse practitioners and two states directly reimburse registered social workers.

Disability programs have demanded much attention in the federal government over the past two decades due to rapid rise in utilization of these programs and the related costs. In Fiscal Year 1981, cash benefits for federal disability compensation programs amounted to $37.5 billion for some 8 million beneficiaries. These programs are listed below.

CASH BENEFITS FROM FEDERAL COMPENSATION PROGRAMS, FISCAL YEAR 1981

Compensation Programs	Payments (billions (of dollars)	Primary Beneficiaries (thousands)
Social Security Disability Insurance	16.9	2,840
Veterans' Compensation	6.9	2,280
Civil Service Disability Retirement	3.1	340
Supplemental Security Income (for Blind and Disabled)	4.4	2,160
Veterans' Pensions	2.4	890
Other Federal	3.8	500
Total	37.5	8,000

SOURCE: Congressional Budget Office Report. Disability Compensation: Current Issues and Options for Change, 1982, p. x.

Of special interest for the mentally ill are the Social Security Disability Insurance (SSDI) and the Supplemental Security Income (SSI) programs.

The Social Security Disability Insurance program was enacted in 1956 to pay wage-related benefits to an insured worker under age 65. It is financed through taxes on employment and covers about 90% of the working population. To indicate the magnitude of the program in FY 1981, 2.9 million disabled workers and 1.8 million dependents were paid $16.9 B in cash benefits.

Eligibility is based on inability to engage in any substantial gainful activity (SGA) due to a medically determined physical or mental impairment expected to last not less than 12 months or to result in death. Eligibility begins five months after the onset of a disability. Termination of eligibility occurs with an extended period of substantial gainful activity or attainment of age 65 (See Appendix C for details).

The seriously mentally ill are among the disabled groups that receive SSDI. However, eligibility requirements may pose problems. The work requirement for a certain period of time with payment of social security taxes poses a significant obstacle for many mentally ill, who have only a marginal work history. In 1982 it was estimated that 243,000 persons were receiving SSDI because of mental illness (Freedman and Moren, 1984). This program provides cash assistance for living expenses and can be an important component to maintaining a chronically mentally ill person in the community (See Appendix C).

A similar cash assistance disability program, Supplemental Security Income (SSI), was enacted as part of the 1972 Amendments to the Social Security Act and superseded a federal program for the aged and disabled SSI with the states. Payments are made to needy aged, blind and disabled persons without consideration of previous employment. Financing for the program comes from federal general revenues, as opposed to a trust fund arrangement like SSDI. Distinctly lower benefit levels than SSDI can be observed. In FY 1981, SSI expenditures amounted to $4.4 billion for 2.2 million blind and disabled persons. Some states also supplement the federal SSI program ($1.2 Billion, FY 1981) allowing greater opportunity for disabled to pay for residential alternatives and other daily living necessities in the community.

SSI recipients must meet income tests on a monthly basis. After becoming eligible, the disabled recipient under age 65 must accept services from the state vocational rehabilitation program. In contrast to SSDI, individual payments for SSI are measured against a basic payment level and are determined in relation to other existing income sources, family status and living arrangements. It has been estimated that 31% of SSI recipients have some mental disorder (Congressional Budget Office, 1982). In 1982, it was estimated that 396,000 were receiving SSI benefits because of mental illness (Freedman and Moran, 1984).

Over the past three years there has been substantial concern regarding the mentally ill and disability determination which culminated in the Social Security Disability Benefits Reform Act of 1984. The major provisions of this bill provide a standard of review for both SSI and SSDI in the termination of benefits. The legislation has other inclusions such as evaluation of pain, multiple impairments, continuation of benefits during appeal, etc. (See Appendix C for details.)

Another major federal funding source for mental health benefits is The Veterans Administration, which was established as an independent agency under the President on July 21, 1930. This consolidated several Veterans' functions into one agency. Today pension and disability benefit programs represent 60% of the budget; medical programs, 33%; and operating and construction expenses, 7%. Both pension and medical programs are significant in providing services to the mentally ill. (See Appendix C for a more detailed description of the Veterans Administration.)

In 1983 total medical care expenditures for the VA system were $8.3 billion. In contrast to Social Security entitlement programs, the VA medical services appropriation is made annually by Congress and is allotted to regional and local medical centers.

Most of the VA care is provided through its 172 hospital centers and outpatient clinics and 101 nursing home units (CBO, 1984). Many long-term care services, however, are provided under contract in community nursing homes or subsidized state veterans' homes.

The VA system provides a broad scope of free hospital, extended care, and ambulatory services to veterans with access limited by a priority and eligibility system. About 10% of the veteran population uses the services in any one year, and 70% of those utilizing the services do not have service-connected disabilities.

Congress enacted legislation in 1970 to make all veterans age 65 and over regardless of need, eligible for medical care. This factor, due to demographic changes, unemployment, Medicare restrictions, and lack of long-term care capacity is putting major pressure on VA capacity, especially for nursing home beds. Rapid aging of the Veteran population indicates that, by 1990, the number of veterans 65 and older will be over 60% of the male population of that age.

VA hospitals are general medical hospitals, usually associated with a medical training and research center. Surgery is performed at 136 of the 172 hospitals. Acute psychiatric care is available at 128 hospitals. Eighty thousand beds are utilized on a daily basis with approximately 30% devoted to psychiatric care and nearly 30% used for extended care.

Mental health benefits are substantial in the VA system with extensive inpatient, outpatient and long-term care services. The Veterans Administration is a vertically integrated program which is now moving out to purchase more services from the community in the area of long-term care. With the cutbacks in both private and public third party coverage, the VA is experiencing increased demands for all services including mental health coverage and services to the longer-term mentally ill.

The Education for All Handicapped Children Act of 1975 (P.L. 94-142) is designed to assure that all handicapped children receive a free and appropriate public education with a full complement of services necessary to assure the effectiveness of the educational program. The Act requires an Individual Education Plan (IEP) for each handicapped child with a statement of each child's performance, annual goals and short-term instructional objectives, and services to be provided to meet those objectives. Each IEP must be reviewed at least annually. The 94-142 legislation is another example of an entitlement type of program. However, it differs substantially from the health and disability programs just discussed. It provides an entitlement for all handicapped children, but provides a relatively small portion of the costs. These federal monies supplement basic local and state dollars funding these programs.

P.L. 94-142, under Part B of the Act, provides basic state grants to cover a percentage of the costs of providing special education and related services to handicapped children. The education and related services supported under this program must have a federally-approved state plan. Funds are allocated to states on the basis of a formula which incorporates the number of children being served in that state as well as the average per pupil expenditure nationwide. State educational agencies receive the federal funds and distribute 75% to local educational agencies. Other parts of the law include pre-school incentive grants determined on the basis of how many 3 to 5 year olds are being served (See Appendix C).

This entitlement and development of services give to 350,000 emotionally disturbed youth opportunities for special services and learning environments. There continues to be some confusion as to how payment mechanisms will be coordinated to fund residential treatment for more seriously disturbed youth who also are entitled to a free and appropriate education under the law. State and local special education funds, along with restrictive Medicaid options and state mental health agency dollars, usually form the core of public funding support for many emotionally disabled children and adolescents.

Under other federal special education legislation, special programs have been established for Regional Resource Centers, early childhood education, innovative programs for severely handicapped, training for educators, research and demonstration projects, and instructional media for the handicapped.

Other major federal funding sources come in the form of categorical grants and block grants to states. Many of these have been recently reauthorized with several programmatic amendments. Categorical grants include Developmental Disabilities Assistance for state planning, research, and service projects within certain priority areas for the developmentally disabled; Rehabilitation Act funds for rehabilitation services to the handicapped with emphasis on the most severe; and Vocational Education Act funds to expand and improve vocational education programs with designated set aside (10%) for handicapped persons.

The Rehabilitation Act of 1973 authorizes over a billion dollars in Federal support for training and placing mentally and physically handicapped persons into employment. Basic State Grant Funds are the major portion of funds under this act given to states on a formula basis. In order for states to receive these federal funds, they must be matched by state funds. Federal funding must comprise no more than 80% of the state dollars spent in this area.

Another federal categorical grant program of special interest is the Older Americans Act which administers grants to states for support of elderly at the community level. These support services include programs for residential, home health, transportation, and nutrition services which can be of assistance in caring for elderly populations with mental disorders. In a recent set of amendments, priority services for Alzheimer's victims and their families were identified (See Appendix C).

The Job Training Partnership Act provides grants to states for job training and related activities for economically disadvantaged, disabled, and other individuals. This is an important new program which has potential for reintegrating recovered mentally ill into the work force.

The Elementary and Secondary Education Act (ESEA) provides, under Title I, grants to states for comprehensive educational programs for handicapped children in state supported schools as well as Title IV grants for developing program activities for handicapped children and other special groups. These ESEA programs are in addition to the previously mentioned Education for All Handicapped Act, which provides education and related services entitlement to mentally ill and other handicapped children.

Another important educational program is provided through the Vocational Education Act of 1963. It provides grants to states to provide basic vocational education programs, including cooperative vocational education, industrial arts programs, and placement services. Ten percent of these grant funds must be used for programs for handicapped, such as the seriously emotionally disturbed. New amendments to this act guarantee equal access of handicapped to a full range of vocational education services.

A variety of other special grant programs provide additional support services for longer term needs of mentally disabled persons, including housing acts with direct loan grants and rent subsidies, transportation acts with provisions for disabled, and various other specialty services.

Block Grant Funding. The Omnibus Budget and Reconciliation Act of 1981 (OBRA) created nine block grants to states for a variety of services. These grants have been summarized in Appendix C as well as the OBRA legislation creating them. Of special concern in financing mental health services is the Alcohol, Drug Abuse and Mental Health Block Grant (ADMBG) which is the federal grant successor to the Comprehensive Community Mental Health Centers Act and the short-lived Mental Health Systems Act.

The Alcohol and Drug Abuse and Mental Health Services Block Grant (ADMBG), had appropriations in FY 84 at $46.2 million. ADMBG consolidated five different kinds of federal assistance programs. The mental health portion of the grant grant allocates funds to states for the operation of community mental health centers for specific services, with emphasis on chronically mentally ill, mentally ill elderly, and coordination of mental health and health care services. States have been allocated funds under the ADMBG with a formula related to past spending under the categorical programs it consolidated (see Appendix C).

Recently new ADMBG legislation has been signed into law with an appropriation of $490 million for FY 85. Provisions of the renewed block grant call for a new funding formula to states (See Appendix C) based on population and per capita incomes. There is an additional provision that no state will receive less than previously awarded. Block grant funds have been earmarked: at least 5% for new and expanded alcohol and drug abuse services for women; at least 10% for mental health services for severely disturbed youth and unserved and underserved populations.

Of special interest to states is the new ADMBG provision that increases from 15% to 25% the amount state's can shift between alcohol/drug abuse and mental health programs. Other items in the Conference Report include data collection on utilization of the block grant; state mental health plans with emphasis on elderly, chronically mentally ill, and youth services; and expansion of the community support program (CSP) concept to the elderly.

Other block grant programs of special interest in the prevention area are the Maternal and Child Health Services Block Grant for health care to mothers and children and the Preventive Health and Health Services Block Grant for a varied group of community programs, including rodent and fluoridation programs, comprehensive preventive services to defined populations, improving emergency medical services, and rape prevention.

The largest block grant to states is for Social Services. This is the successor to the Title XX entitlement program which operated previously by providing reimbursement to states on a 3 to 1 matching basis for eligible services provided to eligible persons. The Social Services Block Grant is allocated to states on a per capita basis. One of its primary goals is to prevent institutionalization through provision of a range of community-based services. State discretion in defining services to be provided under this block grant is broad. Federal legislation identifies, but does not limit states to delivering the following services: homemaker; adult day care; transportation; training and employment; information, referral and counseling; preparation and delivery of meals, health support services; and services to meet the special needs of children, aged, mentally retarded, blind, emotionally disturbed, physically handicapped, alcoholics and drug addicts. Because of limitations on the block grant funding, states must make allocation decisions regarding how much of their social services money goes toward which services and which populations. Each state must file an annual expenditure plan for their block grant allocation. The Social Services Block Grant has the largest amount of funding of the annual block grants to the states. Portions of its $2.7 billion national appropriation have gone in many states for support services for chronically mentally ill.

Multiple Federal Funding Sources. The multiplicity of potential federal funding sources for mental health services have just been summarized. It is this group of entitlement, categorical, and block grant sources which provide portions of the needed set of services. Federal funds alone add significantly to the "patchwork" of mental health financing. This past summarization of major federal funding sources illustrates the significant numbers of programs and dollars which supply different pieces of the services system for the mentally disabled. More detailed information on these programs can be found in Appendix C.

With more severe mental illness, more funding sources and related programs are necessary to maintain persons in the community. Housing, food, medical care, transportation, day activity, rehabilitation services, and case management become essential to the progress of the chronically mentally ill person. At the other side of the continuum, block grant programs may provide preventive services for parents, high-risk infants, and young children which can be critical in reducing the numbers of disabling mental health problems.

Many of the federal program resources flow directly to state governments and are included in appropriations of major state agencies. Next we will look briefly at the major contributions of public state and local level financing.

State Funding for Mental Health Services

The multiple funding sources at the federal level have just been described. These funding sources must interface with state mental health financing. States for many years were the principle source of financing for the mentally ill. With the initiation of deinstitutionalization, changes in service delivery patterns occurred. New federal sources, as just described, emerged to support some community services, long-term care, and income maintenance programs for the disabled. State funding patterns also began to change with declining state mental hospital occupancies and increased pressure for a range of community services.

State government often has been seen as the centerpiece of the mental health system. The state has multiple roles as planner, provider, regulator, and payer. States develop laws which govern the rights of patients and define the community-based service system. State laws also regulate standards for public and private providers and private third-party payers and make major appropriations to state operated and community facilities.

In contrast to the federal role as payer, state public financing for mental health services is focused on appropriations to the state mental health authority (SMHA) and other related state agencies. SMHA's are the legal entities in all states having the responsibility of distributing service funds under SMHA control. The SMHA allocates funds to private and public providers to perform specific mental health services for designated populations. SMHA's nationally administer public mental health delivery systems that own, operate, fund and/or supervise over 12,000 facilities, agencies, and programs (Toff, 1984).

SMHA's must be accountable to the state legislature, the governor, local and federal government, providers, advocate groups, to the recipients of services under its jurisdiction, and to the public at large who pays the bill (Toff, 1984). This accountability to multiple constituencies is important in the SMHA's policy role in planning and funding the type and scope of institutional and community-based services and identifying which populations will receive priority in terms of services. Each SMHA is unique, responding to 50 different sets of state laws that establishe its responsibilities. However, there are commonalities in their functions and financing decisions.

State Mental Health Expenditures. At the state level, approximately 80% of funds for financing the state mental health authority comes from state general revenues (Mazade and Glover, 1984). Of those funds under the control of the state mental health authority, on average approximately 70 to 75% are utilized for state institutional operations with the remainder going to a variety of community services.

Funding for state mental health authorities comprises approximately three to five percent of state budgets. The state department of mental health is seen as the coordinator and chief planner for statewide mental health services. However, many of the funds that go into a comprehensive set of community services do not fall directly under the jurisdiction of the state mental health authority. Originally, the entire mental health system was in one department which primarily provided state institutional care. As community services grew, many funding sources were utilized outside of the state's control which has led to some of the fragmentation seen in service delivery.

Recent studies (Mazade and Glover, 1984) indicate that at least as much or more funding is in other state agencies as that found in the state mental health authority. One of the biggest policy issues now for states is to determine which services it will fund of those needed for the entire system. All services cannot be provided with state funds. Developing priorities for services has become a major dilemma for state mental health systems.

In addition, state mental health agencies must select priority populations and within the past few years have increasingly identified their role as treating and caring for the most disabled. This has brought about a concentration of effort on the chronically mentally ill (Rich, 1982a) and a pulling away from earlier interests in prevention. It has also provided potential conflicts in funding comprehensive mental health centers that found their legislative heritage in a full range of services to a variety of population groups.

Increasingly state mental health agencies must coordinate their services with other agencies that fund services to mentally ill, including education, corrections, welfare, child and family services, substance abuse, and public health. It is this cross-agency planning which becomes important for greater productivity in a time of constrained resources.

On a national basis in FY 1981 SMHA's collectively administered over $6 billion dollars. The SMHA usually is the recipient of federal ADMBG funds as well as the designated agency to administer other federal funds programs, such as portions of Title XIX services and Social Services Block Grant funds. States also receive NIMH funds for special grant programs, such as the Community Support Program (CSP) for the Chronically Mentally Ill, and the Child and Adolescent Service System Program (CASSP) for severely emotionally disturbed youth. States may also receive NIMH extramural research grant dollars awarded to research programs administered under the state authority..

Clearly the most critical role of the SMHA is in planning and setting direction for the development of a comprehensive system of mental health services statewide and then determining which populations and what services will be recipients of the funds under control of the SMHA.

The more recent concentration of the SMHA on the chronically mentally ill has brought about major progress in development of community residential and psychosocial rehabilitation services for chronically mentally ill. This has raised commensurate questions about less available funding in such areas as child services. Systematic early intervention with pre-school and primary grade children in the developmental process can produce significant positive results.

The State Mental Health Authority and the State Hospital. One of the toughest SMHA allocations issues centers around the future role of the state hospital and the significant amount of resources required to maintain that service when most patients are treated in the community.

This subject has been addressed by many authors and studies (Braun et al, 1981; Goodrick, 1984; Kiesler, 1982b; Okin, 1983; Stockdill, 1984; Talbott, 1980). State hospital beds declined sharply from 560,000 in 1956 to 138,000 in 1980. The significant rise in those handled in the community during the same period continues to raise questions about why most states spend almost 70% of the SMHA revenues on state hospitals.

The state hospital continues to play a significant role in the delivery of comprehensive services. It focuses increasingly on legal status patients, multiply handicapped and those with severe behavior management problems.

These patients must be cared for in some manner. Historically the private sector and many communities have lacked the capacity, willingness, and/or expertise to care for many of these patients. The private sector also feels that states have not offered appropriate financial incentives to the private sector even if appropriate staff, secure or more restrictive facilities were available in the community.

Possibilities for consolidation of state facilities and significant reduction in state operated beds are directly dependent on what alternative services can be developed. These alternatives depend on the interest of communities and cooperation of the private sector in providing services to more severely disabled clients. Some of these barriers to private sector cooperation have been identified.

A key factor needed is the cooperation of general hospital psychiatric units and psychiatric hospitals who will accept both voluntary and involuntary seriously disturbed patients. Difficulties in this task have been identified as fiscal, legal, programmatic, aftercare service availability, and the influences of stigma (Okin et. al., 1983). Hospitals are most concerned about the financial risks of these patients who may demand higher staffing levels. These patients often have no private insurance and rely on Medicaid rates which generally are lower than private payors. Low physician rates under Medicaid provide additional disincentives for adequate physician coverage in private inpatient facilities and outpatient services.

Other concerns of the private sector relate to mixing of voluntary and involuntary patients, mixing poor, chronic populations with privately insured patients, and the lack of assurance of aftercare and community alternatives thus prolonging hospital stays in an acute unit (Okin et al, 1983).

Legal concerns related to insuring rights for involuntary patients including establishing guardianship when necessary, the right to refuse treatment and time for court hearings for committed patients are disincentives to private sector cooperation. These have been some of the persistent issues in the public/private interface involved in substantially reducing state mental hospital beds.

Some of the major proponents of state hospital closure emphasize basic problems inherent to the state hospital operational structure that are difficult or impossible to solve. These include condition of physical plants, quality of staff and treatment programs, lack of coordination with the overall service system, and preoccupation with bureauratic procedures and cost containment rather than quality of care and innovation (Talbott, 1980).

Other problems for state hospitals include total reliance on state appropriations, continuing investigations by accrediting, advocacy, and media groups, and lack of an outside constituency with which to improve funding, staffing and programs.

Others advocating closure have emphasized the vulnerability of the state hospital due to changes in our economic system and the state hospital's decreasing occupancy and rising fixed costs (Goodrick, 1984). State hospitals represent a declining industry which will be increasingly pressed by competitors for the same dollar. The need in the public system is to reduce state institutions enough so as to shift savings to essential underfunded community alternatives. There will always be a need for state hospital beds, but the question is at what level should they be maintained.

Talbott (1980) indicates there are four options for the state hospital: closure, maintenance of status quo, radical reform, and alterations in function. Due to the political pressures both for and against closure, it can be anticipated that a gradual alteration in function with some closures and consolidations of existing state hospitals appears most likely.

Clearly dramatic downsizing of capacity will not be possible unless community capacity can be built to care for many of the types of patients currently housed in state facilities. Alterations of functions could lead to specialty hospitals for certain populations of aggressive, assaultive or seriously deteriorated patients. State hospitals also could be reoriented and refurbished as domiciliary care facilities (Talbott, 1980). Other uses include transformation to prison beds or, if location permits, to a residential and recreational site with mixed housing including units for disabled.

One of the biggest dilemmas in SMHA financing, then, is the increasing demands for accreditation, better staffing levels, and programmatic quality in state hospitals at the same time funds are needed to develop community alternatives for future capacity.

In making funding decisions at the state level, it becomes apparent that systems are interdependent. For example, with high unemployment there is an increase in mental illness, more persons are without insurance, and there are increased demands on public inpatient and outpatient services. As one financing change is made, it creates new pressures in another part of the system.

Kiesler (1982a) also emphasizes that mental institutional care has not declined; it has just shifted to another sector, primarily following the availability of the insurance dollar and its bias toward institutional care.

The SMHA of the future must continue to plan for a system of services with even greater concerns for cost management and the specific services to be funded. It will have to wrestle with an ever changing public/private interface trying to reach a balance so that as many persons as possible receive service. The state will continue to be provider of last resort as it juggles its service priorities among the payment systems of the private sector, state appropriations and the funding streams of federal entitlements and categorical grant programs.

Local Public Funding

Local public funding is inextricably linked with state and federal funding policies. Local government and quasi governmental mental health boards must fund services with the revenues under their control within the parameters of the legislation that defines their existence.

Hence, local public funding of mental health services must work with and around established federal and state funding sources. The degrees of local funding responsibility and service delivery decisionmaking vary substantially from state to state and even between local governments within a single state.

It is important to note that some of the most extensive funding sources impacting individual client services at the local level are the federal entitlement programs of Medicare, Medicaid, SSI, SSDI, and the Veterans Administration over which local governance boards have no control. Local public funding often goes toward services in the comprehensive system where there are fewer state and federal resources. For example, local tax dollars are often directed at prevention and early intervention services, special youth outreach programs, information and referral, and public education efforts where less attention may have been directed by federal or state funds.

Local Government and Mental Health Services. The importance of local government in the provision of services to the mentally ill has been less noticed due to concerns about the state institutional system, the impact of federal entitlements, and the community mental health center developments. However, local government's role has grown on a parallel with the community mental health movement.

Following the passage of the federal community mental health legislation in the mid 1960's, states began developing statutes which authorized the state to fund or reimburse local governments for community mental health services. Since then, local governments, either counties, municipalities or townships have taken a role as priority-setters or providers of community mental health services.

For instance, local governments have two important functions in the mental health service delivery system: as an administrative arm of the state and/or as a locally-elected and responsive general purpose government.

Counties have assumed varying responsibilities in the community-based mental health service system: planning, funding, administering, and/or operating. In 1976, 74% of counties indicated some responsibility for mental health services (County Yearbook, 1977). In addition, over 50% of states encourage or mandate their units of local government to assume responsibility for the mental health system at the local level.

Many counties in most states choose to use their own revenue to support community mental health services regardless of the type of statutes or governance structures. A GAO Study (1977) found that over 66% of community mental health centers received up to 37% of their budgets from county funds.

Much of the role of counties is defined by state legislation, as there is an effort to balance roles as well as power. One review of mental health statutes indicated that most states simply permit local involvement while a more limited number require local service provision. In terms of statutory provisions, the most common pattern within a state is to allow counties to exercise their taxing authority to establish and fund mental health services.

If local taxing authority and responsibility is required, elected officials want to have some control over those duties. Five models related to administrative control were identified by Janovsky et al (1980). These include participation of elected officials (1) in a single county exercising direct control over federal and state funds; (2) with power to review and approve decisions by a single community mental health board regarding federal/state/local funds; (3) with authority to review and approve decisions of a multi-county mental health service board; (4) in making expenditure decisions as a mental health service board member; and lastly (5) officials appointing all or a majority of mental health service board members who make decisions on state or local fund expenditures.

In each of these models, specific accountability can be traced to the elected county officials. In states where laws do not create some type of community mental health service board, service provider boards often contain appointees of elected county officials.

It is clear that counties are playing an increasing role in mental health service delivery through a variety of functions related to state statutory provisions. It is anticipated that local government's role will expand with increasing pressures on state and federal funding sources. Increasingly, there will be need to define which services and what populations each level of government will be responsible for.

There are a number of mechanisms utilized by states that allow local governments to participate in financing the service delivery system.

Twenty-five states now use matching formulas to distribute funds to counties, bringing greater pressure on local governments to identify, raise and earmark local dollars and to participate in planning a system of services financed through a variety of public/private and federal/state/local sources. Each state and local area is unique, but certain common themes emerge.

To summarize, three dimensions of local government involvement in the delivery of mental health services have been identified: administrative control over funding; direct delivery or funding of services; or, priority setting through control or representation on community mental health services boards (Janovsky et al, 1980). In addition, there is shifting of financing responsibilities between levels of government for different services and priority populations.

The county can be caught in the middle between local contract providers and state regulations and priorities in the disbursement of funds. Some states give counties a "block" grant with which to manage as effectively as possible allotted state funds. Other states fund directly services in counties where local funds are also awarded. This leads to problems of jurisdiction and potential conflict if cooperative planning is not present. Coordination, however, has been somewhat streamlined with the recent consolidation of some federal categorical programs previously discussed. Local mental health services also must be coordinated with other state agencies, as previously mentioned. Agencies such as child welfare and corrections fund various types of community services in addition to those supplied by the state mental health agencies. County boards or other entities as designed need to have a comprehensive plan for human services in order to coordinate all existing programs for an effective delivery system.

This completes an overview of some of the major public funding sources at the federal, state and local levels for mental health financing. Major sources of federal funds come through federal entitlements to individuals and to providers for services to eligible persons. Generic health, cash assistance and educational entitlement programs available to those needing mental health services exceed, nationally, the total dollars under control of the SMHA's, the centerpiece of individual state planning and service provision. These federal and state dollars flow to recipients at the local level while local governments assist in coordinating the use of federal and state dollars with their own revenues.

While public dollars dominated services funding for mentally ill for one hundred years, there has been rapid growth in private third-party payments for some mental health services over the past three decades. These changes will be examined in the next section.

Private Sector Financing

This monograph emphasizes that the availability and use of mental health services are determined often by the financing and reimbursement systems. This theme is repeated when historical and current private funding patterns are discussed.

Private insurance and other private third-party payment systems, such as Health Maintenance Organizations and self-insured corporate plans, have developed a variety of mental health benefit packages. This movement towards mental health insurance began in the 1940's and grew rapidly as an hospital inpatient treatment benefit. This corresponded to the opening of general hospital inpatient psychiatric beds as an alternative to public institutional beds for those with mental health benefits in third-party coverage. The availability of private benefits for mental health care has been increased substantially, partly through the efforts of advocacy groups and activities related to state mandates.

This section looks at the private third party payment system and its current evaluation in financing mental health services. A quick overview of mental health insurance development is followed by the progress on state legislated benefits. Some significant changes now occurring in the private reimbursement system are identified, including increased competition, new payment mechanisms, cost control measures, redesign of benefit packages, and corporate prevention efforts. Consumer demands, employer needs for cost control, and competitive policies are affecting what is offered in the marketplace.

Brief Historical Perspective in Private Payment. Historically the poor had little access to private services and, as their conditions became severe, they ended up in public institutions. The very rich were able to purchase service on a fee basis or perhaps utilize the few private mental hospitals. This began to shift with the advent of community mental health centers, expansion to outpatient care, and the expansion and improvement of mental health benefits under private commercial and non-profit insurance programs.

The mental health system expanded substantially in the 1960's and 1970's due to increased resources of public and private third-party financing. The increased third-party resources also paralleled a shift in the type of care as outpatient expanded; general hospital short-term, acute psychiatric beds developed; and state and county mental hospital capacity decreased.

When general health insurance coverage began in the 1930's, mental disorders initially were excluded. Fifty years ago serious mental illness generally meant long-term or lifetime hospitalization in a public institution. The growth of private mental health benefits was instigated by the major changes taking place in the system: development of community-based settings; psychopharmacological research findings, and new treatment approaches.

During the same period major changes in the general health system were taking place. Remarkable gains in technology and care were reflected in growth in the health insurance industry. In 1940 ten percent of the U.S. had hospital insurance. By 1970, 78% of the population had some type of hospital coverage (Reed et al, 1972). In 1977, of those with private insurance, 87% had some mental health coverage (National Center, 1981). For the most part, this insurance development discriminated against mental illness coverage by limitations on services and co-payment requirements. Some of this discriminatory policy reflected the public and payer uncertainties about the causes of mental illness, doubts about appropriateness and efficacy of some treatments, and confusion related to medical, social and rehabilitative models of care. As psychiatric treatment moved to outpatient settings so did reimbursement. Outpatient coverage in the 1950's resulted in some unfortunate experiences due to reimbursement of long periods of psychoanalysis, often with persons not seen as sick or disabled. This experience, combined with stigma, has had pronounced effects on limitations in private third-party outpatient coverage (Corrigan and Koyagani, 1982).

Current Employer Coverage. In the 1980's, patterns of private coverage for mental health services vary widely. Mental and nervous disorders coverage is prevalent, but it is rarely covered on the same basis as other conditions. Differences are least in coverage of inpatient services and greatest in regard to ambulatory services. The majority of group major medical expense policies cover inpatient care on the same basis as other conditions (Muszynski et al, 1983). Most out-of-hospital care has special limitations in major medical coverage, usually a 50% co-payment and limitations on visits and/or amounts paid per visit. Coverage is usually more restrictive for plans with fewer employees.

Signs of cutbacks in all mental health insurance coverage with cost-containment efforts in the 1980's is a theme already evident in a recent Health Insurance Association of America survey. The survey showed a decline, from 80% in 1975 to 65% in 1980, of those insured in full for hospital charges (Muszynski, 1983).

To better understand existing private sector mental health coverage, a survey was undertaken (Muszynski, 1983) of 300 plans providing psychiatric benefits to 13.5 million employees in 33 industrial and non-industrial groupings. Findings indicated that coverage is substantial: 6% provided the same inpatient and outpatient coverage as for other medical conditions; 59% provided same inpatient coverage as for other conditions, but with reduced coverage for outpatient; 3% provided the same outpatient coverage as for other conditions, but reduced coverage for inpatient; and 31% of programs provided reduced coverage for both inpatient and outpatient care.

These findings reflect the overwhelming bias in the U.S. insurance industry toward in-hospital psychiatric treatment, despite evidence that for many patients non-hospital treatment can be more effective and less expensive. In developing benefits, insurers should be cognizant that mental illness refers to a number of different disorders with varying client levels of disability. Flexibility in treating mental illness should be encouraged. "Health care follows the dollar;" if insurance covers only certain treatment settings or modalities, they will become more prevalent. Insurers, however, question unlimited benefits due to concerns about documentation of which diagnoses and what services should be anticipated for a given condition or diagnosis.

Business and industry are trying to control costs by responding in a variety of ways related to mental health benefits. Some are actually increasing certain benefits as a response to several studies indicating how mental health benefits can reduce overall health care utilization. Employers who have expanded coverage for mental health care in order to lower overall costs have met with variable results. Some have experienced lower health costs while many others have felt the added costs of additional mental health services.

Most employers are looking at ways to cut costs through benefit redesign and use of alternative providers. Others also are promoting the preventive use of outpatient services, employee assistance programs and wellness plans to cut mental health costs.

Mandated Mental Health Benefits. Over the past decade, mental health advocacy groups sought to have mental illness treatment on a par with other medical conditions. One of the foci for private mental health coverage was through activities in state legislatures to secure mandated benefits. Legislative action has been pursued due to belief that stigma can substantially alter insurance coverage in both public and private third-party (Corrigan and Koyanagi, 1982). Much of the historical opposition to coverage has been based on charges of excessive utilization and uncontrolled costs. However, many state legislatures have recognized the need for coverage of mental and emotional problems, often realizing that public care has been provided for many for whom private care would have been possible if better coverage were available through employee health benefits.

A review of the past and current status of mandates for mental health coverage reveals major activity in this area. Each state, through the federal McCarran-Ferguson Act of 1945, has responsibility for regulating the insurance industry in that state. As of September 1983, 39 states regulated either mental health, alcohol, or drug abuse benefits. Twenty-six states regulate mental health benefits specifically with fourteen of those states putting some type of mandated benefit package into the legislation.

The major opposition to mandated benefits has come from the insurance industry that argues for free market conditions and determination by consumers and employers regarding the inclusions in insurance packages.

Such mandates may also remove incentives for providers to respond to authentic demands for high quality programs and may prevent legitimate carrier cost containment. The mandated benefit may not be appropriate in achieving a balance between clinical and financial needs because it is defined by a political, not a technical process. Mandates also may encourage other change in insurer organizational status to avoid the mandate's jurisdiction.

Currently, increased competition among insurance carriers, rapid expansion of Health Maintenance Organizations (HMO's) and Preferred Provider Organizations (PPO's) and development of corporate self-insurance are changing the environment for and applicability of some state legislative mandates.

Advocates believe that mandates have improved substantially private availability of mental health coverage over the last decade. It is believed that legislation is needed because of stigma and the public's commensurate denial of the rate of mental illness and their potential need for care. Mandates also attempt to address public confusion over what constitutes adequate coverage.

Progress is evident. Estimates indicate now that at least 63% of the population has hospital coverage for mental illness. But only 37% have outpatient coverage which is further limited by higher co-payments and other service restrictions (Corrigan and Koyanagi, 1982).

Developing State Legislation. If state benefit legislation is enacted, it is necessary to develop a statute which takes into consideration individual client need. Therefore, a range of settings and providers should be available including inpatient, partial hospitalization and outpatient services. In addition, licensed state professionals, reasonable service setting limitations, and lower co-payments should be addressed in any comprehensive legislation. Although there is no consensus on reasonable coverage, some recommendations have been made for inclusion in mental health benefit legislation.

The contents of different states' legislation vary greatly. However, according to Corrigan and Koyanagi (1982), certain components should be present in order for appropriate impact to be made on securing private third-party funding. These content recommendations include a definition of the term "mental illness and nervous disorders"; type and extent of treatments to be covered; treatment settings and standards to be met by provider agencies as well as quality assurance procedures; identification of professional providers who will do treatment; and, finally, the types of policies and third-party payers that are included and/or excluded from the mandate.

Some of the recommendations for specific legislative inclusions include treatment coverage (Corrigan and Koyanagi, 1982) for inpatient care for at least 45 to 60 days per year with no distinction between general and psychiatric hospitals; outpatient care at a minimum of 20 to 30 visits per year; and between 45 and 90 days per year as a minimum for partial hospitalization which also can be traded with inpatient or outpatient to provide an incentive for less costly partial hospitalization and/or outpatient services. This is not seen as an ideal but as a guide proposed by some advocacy organizations for assisting in the development of legislative activities.

Current Legislative Activity on Mandates. Despite criticism of mandated insurance benefits, the current viability of the legislative route is reflected in the substantial activity in state legislative halls regarding mental health benefits in this past year. Across the U.S. during 1984 state legislative sessions, fourteen states introduced legislation affecting private health insurance coverage of mental illness, alcoholism, and drug abuse (Toff, 1984).

Following the need for more comprehensive alternative service inclusions in mandates, three states are considering legislation that would mandate specific benefit packages for mental illness coverage under certain health insurance contracts. One initiative addresses the need for longer-term non-hospital residential and transitional living services by requiring 120 days of benefits for residential treatment per policy year.

Need for private insurance to supply more components of service is evidenced also in a California legislative proposal requiring group policies to offer coverage of community residential treatment services for persons with psychiatric disabilities. New York has a legislative proposal which further responds to the system of services concept by proposing that group policies covering inpatient hospital care also provide coverage for diagnosis, evaluation, and crisis intervention of mental and emotional disorders on an outpatient basis.

These proposals reflect the need for coverage of a system of services which provides for varying levels of client care and recognizes special needs for diagnostic and longer-term, less expensive, non-hospital residential services.

Long-Term Care and Private Insurance. It is important to note that most private third-party insurance does not cover the more serious, chronically mentally ill. These are long-term conditions requiring a comprehensive array of services including community residential alternatives, supportive daily activities and rehabilitation training as well as extended or intermittent inpatient and/or nursing home related benefits. Most of these are not covered generally under private insurance which has focused on acute medically oriented care. Recently there have been explorations of long-term care insurance.

Pressures on Medicaid expenditures driven by dramatically increasing long-term care costs are spurring interest in this long-overdue area of potential utilization of private resources. Private insurance accounts for a negligible portion of long-term care expenditures. To illustrate, in 1979, 97% of private expenditures for nursing homes was direct out-of-pocket payment. Only 1.5% was private third-party reimbursement. Most of the discussions around long-term care insurance have centered on coverage for those 65 years and older.

Lack of availability of long-term care insurance has been attributed to the availability of public long-term care programs as a "safety net" which make the private market less attractive. Many competing costs for the elderly have appeared to the industry to make such coverage less marketable. Also, many elderly believe Medicare covers long-term expenses when, in fact, Medicare does not address long-term care. This is evidenced by the fact that only 7% of Medicare expenditures in 1981 were for long-term care.

In fact, Medicare covers only 100 days of skilled nursing care (SNF) with a copayment required after the first 20 days. Restrictive, complex criteria can make access difficult to Medicare's limited SNF and home health benefits.

The private insurance industry has shown limited participation in long-term care financing for one basic reason: it is not profitable. Two major factors make this true. The first is adverse selection. This means that only those with a relatively high risk of needing long-term care would take out a policy. In order for a private insurance firm to make a profit, the risk has to be spread more evenly across the general population, but the general population is not currently of a mind to invest in long-term care insurance. The other major obstacle keeping private insurance out of long-term care is induced demand. That is, the tendency for utilization of a service to increase dramatically once it is insured against. Both of these factors may inhibit profits for insurance companies and their participation in long-term care financing.

The availability of public resources and the lack of public understanding of need for long-term coverage reinforce the private insurers' concerns of adverse selection, insurance-induced demand, "administrative economies, and premium pricing difficulties due to inflation" (Meiners, 1983).

Additional problems in developing the long-term care insurance product include setting limits for long-term care coverage. Another obstacle is the bias against insuring necessary non-medical services, such as homemaker, nutritional, respite and day care supportive services.

With the limited rates for nursing home reimbursements under Medicaid, the growing regulations against divestiture of assets to access Medicaid, and the growing public and state leadership concern over the tax dollar drain to Medicaid, the forces may be converging to provide a better climate for providing private insurance to guard against "catastrophic long-term care expenses" (Meiners, 1983).

Current "medigap" coverage concentrates on filling gaps in Medicare's restrictive skilled nursing benefit for which few qualify. Coverages below the skilled level are important for the majority of the disabled, and dealing with those differences in levels of care has been a barrier for insurers.

Meiners (1983) has proposed that private insurance develop a product that focuses on nursing home care, has limited enrollment time at age 65 years, and covers a three-year stay after a 90-day deductible is met. Premiums have been developed which would be paid over the lifetime of the purchaser. The three year limit was based on data showing 38-55% of elderly nursing home entrants are short stayers after an acute episode. Only 10% admitted stay longer than three years, after which Medicaid could be an option for those whose resources have run out.

Success of any long-term care insurance would be based on ability to screen level of functioning of entrants for appropriate utilization and using home care as a substitute or alternative to institutional care.

Most discussions of long-term care insurance have focused on the elderly to cover the needs that the institutionally biased, acute Medicare program cannot meet.

At this point, the non-elderly categorical populations with chronic mental illness, developmental disabilities, and physical handicaps have not been included in discussions of needed private long-term coverage. As a result of lack of private coverage, long-term care for the mentally ill continues to be financed primarily by federal, state, and local public dollars with the use of many different providers depending on the needs of the client.

Long-term care insurance for the elderly could assist in addressing the serious mental disabilities that are emerging in greater numbers, such as Alzheimer's disease, where institutional care eventually becomes mandatory.

Insurer Perspective on Mental Health Benefit Changes. Gillman (1984), at a recent NIMH conference, presented an insurance payer perspective on what's going on currently in private third-party payment for mental health services. Gillman also spoke to this in the context of state mandates.

From the standpoint of Blue Cross/Blue Shield (BC/BS) and as an insurance manager, Gillman (1984) emphasized that recent limits and reductions in mental health coverage for federal employees by BC/BS were not done out of prejudice toward mental health services. Insurance industry preferences are not dictating current major reductions in a variety of mental health coverages. These decisions have been based on business criteria related to what the customer wants, what the competition is doing, and the products the insurer knows how to deliver and to underwrite. When some health care providers are paid in full and others get only partial payment, this is done in accordance with the contract to the customer. It is not done out of a sense of fairness or is related necessarily to proven effectiveness of a given service.

In discussion of cuts in BC/BS mental health coverage for federal employees, Gillman emphasizes that there are two customers: the federal government and the individual subscribers. The federal government pays 50% to 70% of any plan for federal employees and therefore has a major negotiating role.

The subscriber, just six years ago, identified cost as far less important compared to full coverage with very low deductibles and reduced co-payments.

Now those same subscribers (85%) see cost as one of the first three priorities in choosing a plan. Over 80% of subscribers also ranked mental health as a low priority.

When competing for customers, insurers must offer popular benefits or face loss of business. If BC/BS offers a better mental health benefit than a competitor, those needing the benefit will change and select BC/BS. This will create an adverse selection process which, in turn, will drive costs much higher. This will lead eventually to dropping the benefit or more customers dropping the plan. Insurers look for benefit packages that attract the most people for the price.

Insurers now compete to give employees the benefits they want at the price they are willing to pay. Mandates which single out an individual insurer or group of insurers could be hurtful in such a competitive marketplace. In a competitive insurance market that focuses on cost and premiums, it is extremely difficult for an insurer to cover widely diversified services if his competitors do not.

Ground rules for insuring can make some mental health services difficult to insure. These rules include identifying explicitly the unit of service, the conditions and persons for whom it is appropriate, the qualified settings and persons to deliver the service, and the reasonable price for such a service. Reasonable lengths and types of outpatient programs for specific disorders need to be developed. In private insurance of mental health services, there are debates as to whether third-party financing should be used for services such as employment counseling rather than for a specific designated health problem.

Recent Changes in Payment Programs. The competitive marketplace for third-party payments just described is part of the major changes occurring in the payment mechanisms for health care in general which are impacting mental health services in the private sector. Other changes include the growth of the Health Maintenance Organizations (HMO), development of Preferred Provider Organizations (PPO's), the advent of corporate Self-Insurance, and the utilization of prospective payment systems, such as the Diagnostic Related Groups (DRG's) for inpatient care.

All of these new payment systems and related changes in service delivery are in direct response to the rapid acceleration of health care costs over the past three decades.

In 1984 health care costs in the United States are expected to be approximately $350 billion, which represents more than 10% of the GNP and 12% of the federal budget.

State health costs rank second only to education in developing most state budgets. Forty-six percent of the total costs for health care are borne by public tax dollars so that costs of illness care and the distribution of those dollars among services and populations has become a major public policy issue.

In addition, major rises in health care expenditures for business have led to higher prices for goods and services and more difficulty in meeting domestic and foreign competition.

To curb these rapidly escalating costs, a variety of cost control efforts have been initiated including rate setting, certificate of need, limitation on bed supply, etc. Gradually regulator efforts to control costs have given way to competition as a way to hold down illness costs. HMO's and PPO's are examples of creative responses to these cost control efforts which are having significant impact on mental health service delivery and availability through private financing. A more detailed explanation of some of these payment system changes is presented below.

Health Maintenance Organizations. The federal government has struggled to find a middle ground between regulatory and competitive strategies in holding down health care costs. Search for a strategy that would bring discipline to the medical marketplace through improved incentives is the Health Maintenance Organization (HMO). A federal initiative to supply start-up grants for HMO's was passed by Congress in 1973.

An HMO basically delivers comprehensive medical services to voluntarily enrolled subscribers in exchange for premiums fixed, known, and paid in advance (Brown, 1983). HMO's have treated mental health services in a variety of ways, from minimal to comprehensive benefits. Many HMO's place major restrictions on in-hospital psychiatric care. In addition, HMO plans often exempt ongoing treatment of preexisting, nonacute psychological problems (Armer and Moscov, 1984).

In 1980, about 235 HMO's enrolled about 4% of the population (Brown, 1983). However, with increased competition in the health care marketplace the past four years, this picture has changed substantially. HMO enrollment increased 15.4% between June 1982 and June 1983 with 290 HMO's serving almost 14 million people. California had the highest percentage (21%) of residents enrolled in HMO's. Recent projections indicate that enrollments nationwide will triple to 40 million by 1990.

This rapidly growing payment system will have a significant impact as to how mental health services are delivered and whether they are available for many in the private sector. In general, characteristics of HMO mental health benefits have been summarized (Patterson, 1982) as benefits limited to the ordinary mental health needs of the enrolled population including conditions treatable within 30 hospital days and 20 professional visits per year.

Mental health services will be medically oriented but the mental health staff will also direct energies toward physically ill, substance abusers, elderly, and other presenting problems of subscribers. HMO mental health services will be vertically integrated with incentives to use outpatient alternatives, non-physician mental health personnel, and preventive services. Being a limited benefit cost-conscious program, services will need to be integrated with public resources in the event of extraordinary mental health needs (Patterson, 1982), such as services to the chronically mentally ill.

Preferred Provider Organization (PPO). The PPO presents an additional option in consumer health care and is an association of hospitals and physicians whose services a consumer may "prefer" because of financial incentives. It is a type of Alternative Delivery System (ADS) that has been developing rapidly in the past two years. In 1984 123 PPO's nationwide had been identified; 84 were operational.

The PPO, as a process, can be found somewhere between traditional indemnity insurance and an HMO. It retains characteristics of medical insurance because it incorporates a fee-for-service reimbursement process. The PPO is similar to an HMO in the fact that a consumer may obtain comprehensive coverage from a single organization (Health Care Law Letter, 1983).

A PPO is generally a limited network of physicians and hospitals that provide certain health services to specified insured populations at previously negotiated rates. This network contracts with large employers, insurance carriers, or third-party administrators to provide comprehensive services to subscribers.

No single definition encompasses the many forms of existing PPO's because PPO's specific components and methods of operation are dictated by the competitive environment and prevailing market conditions. However, PPO's have a common core set of elements (see glossary).

It is too early to determine how mental health services will survive within the PPO concept and how they will be included in the range of services offered by PPO's. Specific mental health PPO's can be developed and marketed to large employers, or, if laws permit, contracted even to HMO's for comprehensive mental health care.

The PPO was created as a response to the expanding HMO enrollments and declining physician and hospital resource utilization. The primary goal of a PPO is to increase the participating provider's market share, and this is accomplished through fee discounts and attraction of a larger client base. The PPO can also select the most cost advantageous hospitals and physicians as well as to employ effective utilization review. Physicians appear to like the PPO concept because there is minimal financial risk, a fee-for-service relationship is maintained, and the PPO is self-regulated. For employers and employees the strengths are the wide coverage possible in a metropolitan area and the opportunity for expanded consumer choice.

What is not clear is the potential vulnerability of the PPO from an antitrust perspective. This network of providers (often former competitors) must agree to charge set fees for given services. Also, it is not clear as to the classification of a PPO and how it is subject to state insurance laws or whether it falls under HMO legislation. In essence, the PPO is a new hybrid responding to market competition and designed to reduce health care costs and increase efficiency.

Seven states have passed legislation specifically to foster development of PPO's (State Health Notes, 1984). Some legislation limits PPO's or protects consumers in various ways, including payments by insurers to nonpreferred providers under certain conditions. Other new state legislative proposals address PPO maintenance of quality and exclusion of potential providers as well as the anti-trust issues.

Self Insurance. Self insurance for corporate health care is yet another way to cope with health care costs. Corporations are moving into self insurance for financial reasons. They can utilize cash flow differently and keep their money in their own reserves rather than at the insurance company. Self insurance gives a company some more flexibility and control on how monies should be used.

Self insurance plans are comparable to other kinds of health care plans. The employer, however, puts together, usually with assistance from a consulting firm, the corporation's own benefit package. Companies usually reinsure with a major indemnity company to cover possible losses from major health risks or extended illness, but less serious illnesses or accidents are paid for from regular operating expenses. Most self insuring companies will use the services of a benefits payment firm which evaluates claims made by employees and distributes benefits according to those evaluations. An insurance agency usually administers the benefit program (Boche, 1983).

Such self insurance is important in terms of mental health benefits because any existing state mandates do not apply to self insurance and new benefit packages may not include former offerings. However, if corporations do their own insuring they are more likely to invest in coverage for longer term benefits and, therefore may be more interested in the cost offset opportunities of mental health benefits in reducing future health care service utilization and increasing productivity of the work force.

Self insurance is one of the fastest growing new directions in the health care field. In 1983 approximately 24 million workers were covered under self insurance plans (Boche, 1983).

Prospective Pricing Systems. Another major new direction in health care cost containment is prospective pricing systems, or prospective payment. Under a prospective payment system, rates of payment to providers are established in advance of service delivery on the basis of a specified unit of payment and are utilized usually for a year's duration. In contrast to a retrospective, fee-for-service system, the fixed rates are designed to limit provider payments and to provide incentives for efficiency.

Due to projections of dramatically increasing Medicare costs, Congress mandated a prospective pricing system for Medicare inpatient care to begin in October, 1983. The new payment system is based on Diagnostic Related

Groupings (DRG) which classify patients with similar diagnoses and treatment protocols into one of 467 categories. At this time the system only applies to Medicare inpatient while outpatient services will be reimbursed on a retrospective basis.

Currently there are 15 DRGs for mental disorders, including alcohol and drug abuse. There has been considerable controversy over the development of these DRGs for mental disorders in terms of the cost basis utilized to determine pricing, the lack of homogeneity of groups,and the inability to predict length of stay and resource utilization by diagnosis.

As a result, exemptions have been granted to many inpatient psychiatric settings while alternatives to the proposed DRG's are considered in terms of modifiers to diagnosis as well as regrouping diagnoses into new categories. A report to Congress on studies in this area is due in 1985.

Prospective payment implementation has already had substantial impact on other portions of the health care system with major reductions in hospital occupancy and increased demands for nursing home beds and more sub-acute home health services. In addition, several states have begun using DRG's for their Medicaid inpatient hospital payment system indicating that hospital payment is moving in some areas toward more of an all-payer system. This, in turn, is impacting private payers, their reaction to potential cost shifting, and their increased efforts at discount purchasing as seen in HMO's, PPO's, and self insurance.

The potential impacts on mental health services of prepricing systems are numerous. A few are noted here. The prepricing system will force providers and insurers to define different categories of patients and to develop more coherent treatment protocols.

DRG's focus on an acute treatment system while many mental disorders, especially those requiring hospitalization, are chronic (Goldman et al., 1984). In addition, standardized treatment has not yet been developed for a significant portion of disorders and the mental health system also uses a wide variety of facility types and provider groups, all with different practice patterns, case mix and rates.

Other concerns are that private sector facilities under DRG's will be more selective over admissions, motivated by fiscal incentives, with possible skimming of the better patients while public facilities will experience "dumping" as well as serving as the backup for the private sector and Medicare (Goldman et al, 1984). Because of short hospital stays, nursing home beds will be in short supply, shelter care may not be adequate or available and outpatient services insufficient for more disabled patients who are released too quickly under DRG's. Despite these disadvantages, prospective pricing appears to be a wave of the future to which the mental health system will have to adapt.

Resource Utilization Groups (RUGS) are already under study as a possible prepricing system for long-term care in nursing homes, a mode of care utilized by many chronically mentally ill. RUGS attempt to obtain a more accurate indicator of actual patient costs in a nursing home setting through assessing a resident's level of service based on ability to manage daily activities and the amount of staff time to monitor fluid intakes, continence, medications, etc. Staff time as a measure of resource consumption, rather than diagnosis (as in DRG's) will be utilized to account for variability of patient care cost in long-term care facilities. Nine Resource Utilization Groups have been developed, and it is unclear as to what provisions will be made for dealing with the special needs of the mentally ill in nursing homes in such a categorization and payment system.

However, such a prepricing system will assist in more differentiated services based on client need, potential specialization of nursing facilities, and possible facilitation of long-term care insurance developments in the private sector. All of these are needed to deal with long-term care of mental disorders, especially now with increased demands in the aging population.

The DRG's and the RUGS are indicative of prepricing systems which herald the future in developing new payment systems on a capitation basis in both the public and private sectors. Discussion of the relationships between the public and private sector financing in the delivery of mental health services follows.

Public/Private Interface

The emergence of an accessible mental health system of services is dependent upon a public/private partnership in financing. Considerable time has just been spent on delineating some major sources of funding in both the public and private sectors. In order to provide a full set of services for the multiple populations just described a balance in roles between the public and private sectors must be achieved. The two sectors must be brought together to create a system of services.

The two sectors are interdependent: as one makes a change, it impacts the other. We have just reviewed a series of substantial changes taking place in organization of private third party payments. Major cost control efforts may result in reductions in service availability and/or alternative modes of provision which may be more or less productive than previous service models.

However, the private sector payment system is heavily oriented to acute inpatient care with some outpatient alternatives. Limited aftercare, little funding for community support services, and no long term care provisions clearly focus private payment on less chronic (and often less serious) conditions.

With the increase in private insurer efforts at cost control, inpatient care may be further emphasized. Evidence suggests that this, long range, is a less effective and more expensive utilization of resources for many patients.

The existing insurance system often has provided incentives for more expensive, less effective care and must be seen as only one element in a financing policy for mental health services.

It becomes evident, then, that the present private third party mental health coverage has not developed from a rational sense of the system of services needed. It has responded in an incremental manner filling in and around an existing, originally publicly financed pattern of care (Mechanic, 1980).

Insurance coverage has had a significant impact on the distribution of care by giving priority access often to those who need the services least. Those with higher incomes and educations tend to use the most services. This leads to high concentrations of well-trained professionals in affluent urban areas as opposed to inner city or rural locations. Those who are most impaired tend to end up in the public system where staffing levels often are low, treatment programs limited, and physical facilities of more marginal quality.

Large numbers of persons with mild and more serious disturbances go to the medical primary care sector first. Those referred to the specialty mental health sector from primary care are small in number and usually have more severe symptoms. Depending on payment resources and levels of severity, these persons either enter the public or the private system of care.

The major question that evolves is the extent to which the private sector will deal with the more disabled patient. This seems to be dependent both on the skills and physical capacity of the private agency or service and the rates which are paid for the care of these individuals. Historically, public and private rates have been based on a unit cost or per diem based on the setting and not on the complexity or severity of the case. This has provided incentives to the private provider to "cream" the "easier" patients while obtaining maximum rates and referring more difficult patients onto the public sector.

Increasing tension is developing between public and private sectors in this regard. Fears are developing that with increased emphasis on competition in the private health care marketplace that the extent of mental health benefits may be curtailed. Private providers increasingly may compete for the easier patient with appropriate insurance, leaving more persons to flood into public sector facilities. Part of the tension arises from the earlier successes in getting the insurance industry to offer greater coverage which has led to the expansion of private facililties (Vischa, 1984).

With the rapid development of hospital for-profit chains, some argue that a free market will improve mental health care. Others feel that the more pluralistic competitive system will emphasize care for the middle class and thereby abandon the indigent (O'Connor, 1984) who are often more disabled and difficult to treat.

The ability to downsize the less efficient, more poorly staffed, state hospital is directly related to the role that the private sector will play in providing care. Issues to be addressed in private sector participation and state hospital bed reduction include: mixing of types of patients; development of crisis and acute care in community alternatives, location and security of facilities, staff training; and willingness to treat all kinds of patients. Most importantly, rates paid to the private sector for this care impact the ability to access this expanded private resource.

There are charges that the growth in the private sector has resulted in a clear, two-sector system where the poor are treated by public sector programs and the more affluent are treated by private sector programs (Vischi, 1984). Further, there are concerns that the higher inpatient rates paid in the private sector result in inappropriate utilization patterns to obtain greater profits.

In addition, the newer, more attractive for-profit facilities are seen as taking private pay customers from the "public" agencies. However, there is considerable debate on the bounds of "public" and "private". Many programs which receive public funds are, in fact, in the private sector as private non-profit and for-profit corporations. Most of these programs receive funding from a variety of sources.

Increased moves to cost containment measures , prepaid plans, and third party pre-approval of treatment regimens, may limit profits of the private facilities for most expensive services in the future.

A balance of service provision between the public and private sector must be achieved through an identification of patient groups and services to be rendered. In the future, tremendous costs of state hospital operations will place pressures to provide equivalent or improved services in the community. States, acting as the centerpiece of the mental health system, will need an effective plan and vision of what system needs to be in place so as to most effectively utilize private and public resources. This public/private relationship must be fostered by a shared goal of serving people. This public/private interface takes place at many levels: between patients, facilities, providers, payment systems, and professionals.

In the future this public/private relationship will take place in the context of anticipated evolution (Stockdill, 1984). The state authority role will move toward systems planning, cost containment, evaluation, and quality control. Incentives for program development for more difficult populations and increased purchase of services from the private sector are part of this changing state role.

Putting the Pieces Together

This section of the monograph has provided an overview of financing mental health services from a three dimensional perspective: populations, services and funding sources. Certain observations can be made as a result.

There are multiple funding sources that provide a set of services. Some of the funding sources provide a specific service while others supply several services to a specific population group. Multiple inconsistent funding sources lead to fragmentation in service delivery as well as responsibility.

Providing a comprehensive set of mental health services requires bringing the health and social service systems together. In addition, transportation, housing, food and other community supports must be available if the longer-term mentally ill person is to receive care in the community. In general, the greater the level of disability, the more different funding sources are utilized to access the needed array of services if the client is maintained in the community.

It is necessary to provide, through various funding sources, a full range of services so that inappropriate or over-utilization of one service component does not occur. At the current time, the bias toward inpatient care in the public and private payment systems encourages over utilization of these services. Allocation and redirection of funding must stimulate the development of crisis care, respite, residential alternatives, and psychosocial rehabilitation opportunities to reduce the need for inpatient episodes.

Planning, then, becomes essential to determine which services will be offered at each level of government and to tailor funding resources to meet those needs effectively. Different funding sources have emerged at each level of government. Discrimination of mental illness in federal entitlement financing must be addressed in order to provide services in the future. Recent reforms in disability payment procedures are an important start in this regard. Entitlements for cash assistance and medical services are more federally based. States use their own revenues, federal grants, and Medicaid reimbursement to finance state agencies who in turn purchase and provide services. Local government distributes its revenues in and around what federal and state governments provide. At each level of governance (federal, state, local) there are mixed, and sometimes conflicting roles of government as provider, purchaser, monitor and regulator.

Fragmentation in service delivery occurs when a client moves from one funding source to another across state agencies, between levels of government, and between private and public sectors. Based on historical development and the multiple cross-agency needs to deal with chronic mental illness, it is not likely that funding sources will be dramatically consolidated. As a result, increased efforts at coordination and case management, as illustrated in the NIMH Community Support Program, will be necessary.

It is also evident that funding sources need to be more effectively utilized for programs to meet the needs of special populations, including children and adolescents, women, minorities, elderly, and those in forensic programs. Although there is need for increased allocation, there are needs to redistribute what is being invested and to use it more effectively. This effort needs to be addressed in a variety of ways. More effective diagnostic procedures and placement at the most effective stage on the treatment continuum is a first step. Redistribution of funds from inpatient to an array of community services would better serve the diverse clients involved.

From this overview it is apparent that there are extensive sums of money from both the public and private sectors going into treatment and maintenance of those who are mentally ill or have need of more limited mental health services.

Much more services research, especially outcome research, is needed to evaluate the most successful treatment regimens. This knowledge must be disseminated to other researchers, providers, advocate groups, and policy makers so that these findings can be utilized in a shared consensus to move financing toward the development of a more efficient system of care. Various new private and public payment systems, i.e. prospective pricing, capitation grants for chronically mentally ill, and health maintenance plans are moving towards cost control and efficiency without adequate services research information.

Needs for increased attention to prevention are apparent. Few of the funding sources systematically direct any resources in this area. Prevention expenditures are usually found in specific discretionary grant programs, not in the vast entitlement programs.

Prevention is directly related to research into the causes of mental illness. Where cause and effect have been identified, prevention programs can be more targeted. With the multiple causal factors related to mental health problems, a variety of programs across many agencies can be utilized as efforts in the preventive process. These programs generally cover services to high risk groups, regulatory activities, and promotion and education efforts.

The diversity of opportunity in prevention includes programs such as working with high risk mothers and babies; preventing child abuse and family violence through services to vulnerable families; working for more effective prenatal programs; nutrition education and feeding programs for children; and early identification and intervention in school age children with learning and behavioral difficulties. The opportunities to work in the preventive area are multiple, but the cross-categorical nature of preventive activity and the up front investment for longer-term payoff, make it less attractive. The political funding process is more oriented and responsive to the casualty, categorical areas of disability and the related constituent groups.

However, in order to have more resources to spend on those who need assistance, there must be attendant efforts at prevention, despite the comprehensive concept, in order to have a more productive society and a more limited severe casualty group. Research efforts and findings are tightly linked to more effective prevention planning and use of prevention dollars.

In summary, a comprehensive array of services must be funded through multiple sources in order to meet the many levels of client need for mental health services and for the longer-term care of those with chronic mental illness. This will take the major efforts and cooperative planning of both public and private funding sources, service providers, and advocacy groups.

SUMMARIES
OF
SELECTED PRESENTATIONS
FROM THE
CONFERENCE ON
HUMAN SERVICES FINANCING
STATE ISSUES AND OPTIONS

NATIONAL CONFERENCE OF
STATE LEGISLATURES

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SHIFTING RESPONSIBILITY FOR FUNDING MENTAL HEALTH SERVICES AND CURRENT FEDERAL DEVELOPMENTS

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DR. GOLDMAN DISCUSSED SOME HISTORICAL TRENDS IN FISCAL RESPONSIBILITY FOR CARE OF THE MENTALLY ILL. NOTING THE IMPORTANCE OF STATES EFFECTIVELY ACCESSING AVAILABLE FEDERAL FUNDS, DR. GOLDMAN ALSO OUTLINED SOME RECENT DEVELOPMENTS IN THREE MAJOR FEDERAL FUNDING PROGRAMS (MEDICARE, MEDICAID, SSI/SSDI) WHICH WILL AFFECT THE FINANCING OF STATE SERVICES FOR THE MENTALLY ILL.

Patterns of Shifting Responsibility for Mental Health Financing

Responsibility for providing and financing mental health services has been shifting among sectors and between levels of government over a long period of time. In the pre-asylum era, responsibility for the care of the mentally ill was exclusively that of individual families of mentally ill persons. Public responsibility for the care of the mentally ill emerged when centers of population developed and indigency became associated with mental illness. These developments occurred around the turn of the 19th century.

The turn of the 19th century was a period of much social reform and several changes were made in the delivery of mental health services. Asylums, the first private corporate facilities, were developed out of the idea of and commitment to local charity. However, the facilities soon became unable to continue their responsibility for the mental health needs of the indigent.

The state then assumed some responsibility for the care of dependent mentally ill patients. Widespread establishment of state mental hospitals began in the 1830's. The state built these facilities and paid for the facility superintendent and staff while local governments financed the stay of individual recipients of service when they were unable to pay. However, by the mid-19th century, it became expensive for local governments to send patients to the state mental hospitals; thus two parallel institutional mental health systems were developed: state hospitals and local almshouses.

The state did not assume full responsibility for the care of the mentally ill until the end of the 19th century. State Care Acts were passed, giving state government total responsibility for care and treatment of mentally ill patients. Local governments divested themselves of responsibility by sending patients from the local almshouses and workhouses to the state mental hospitals. There was a huge influx of individuals to the state hospitals; many of these transferred residents were elderly patients in various stages of senility. The state remained the most powerful centralized public force with regard to mental health financing until the introduction of the Veterans Administration System.

The Veterans Administration System was the first substantive federal effort in financing mental health services. An earlier federal effort to develop federal asylums for the mentally ill sponsored by Dorthea Dix was frustrated during the Franklin Pierce administration. The only result of this earlier attempt was the founding of St. Elizabeth's Hospital in Washington, D.C. Other than the Veterans Administration System, the introduction of the Social Security Act in the 1930's (particularly Title II - Old Age Survivors and Disability Program for the disabled and blind) was the most significant federal development affecting mental health at this time.

Shortly afterwards, there was a rebirth of private interest in mental health service provision; private health insurance with mental health benefits was developed. However, private coverage was slow to expand and coverage for mental health services was severely restricted to control possible overutilization. In the 1940's, separate mental health benefits were developed; however, these benefits were also very restricted.

One of the most significant developments in federal responsibility for the mentally ill came with the development of the Medicare, Medicaid and Title XVI Amendments to the Social Security Act in the 1960's. These Amendments created opportunities for federal financing of mental health services, but limitations were immediately imposed on the mental health benefits.

The other significant development at the federal level in the mid 1960's was the growth of categorical mental health financing programs, particularly the Community Mental Health Centers Program. This development established another separate stream of public financing for mental health services uncoordinated with state activities. Only after the 1975 amendments to the Community Mental Health Centers Act was some coordination with the state mental health authority mandated. Results of this mandated coordination were mixed.

In addition to much deinstitutionalization, the 1970's was a period largely of shifting fiscal responsibility for the mentally ill from the state to the federal government. States began to share fiscal responsibility with the federal government and were divested of some responsibility for direct care of certain groups of individuals who could be funded through the federal financing mechanisms. This shift of fiscal responsibility to the federal level continued until the late 1970's.

During the late 1970's, the Carter Administration began the first attempts at new federalism. The Mental Health Systems Act was essentially a step in the direction of shifting responsibility back to the states; however, no use was made of the term new federalism. The current federal administration has intensified this trend by shifting many responsibilities for the mentally ill back to the states through the creation of the block grant mechanism in the Omnibus Budget and Reconciliation Act of 1981. If current trends continue, the states will have to assume still greater responsibility for the care and treatment of the mentally ill and the federal government will assume a smaller share of fiscal responsibility. Moreover, experience suggests that in a period of flux when responsibility is not clearly defined, the mental health system is most vulnerable to neglect and the mental health patient may suffer.

Current Developments in Federal Financing Affecting Mental Health Services

In order to decrease potential problems that may result from this transition, the task of the state becomes accessing effectively the remaining sources of federal funding for mental health care. In order to accomplish this task, it is important to be aware of current developments affecting federal programs that provide opportunities for financing mental health services. Developments will affect the major federal funding programs of Medicare, Medicaid, and Supplemental Security Income/Social Security Disability Insurance.

Medicare (Title XVIII). Medicare is the federally administered program for the elderly and the disabled (as defined by criteria under the SSDI program - Title II of the Social Security Act) which provides benefits for hospital and physician services.

The major action affecting Medicare is development of prospective payment systems. Under the current prospective payment system, mental health care is included if a patient with a mental health problem is 1) admitted to a general hospital medical/surgical bed, or 2) admitted to a non-exempt psychiatric bed in a general hospital. Psychiatric hospitals were excluded because the prospective payment rates were developed using an acute general hospital population. Exemptions are available for any qualified general hospital psychiatric unit and a majority of these programs have requested such exemption. Some general hospital psychiatric programs have been denied exemption and some applications are still pending.

A research contract (18 months) has been established between NIMH/HCFA and MACRO SYSTEMS, INC. for evaluation of various systems for classification of psychiatric disorders. It is hoped that the study will identify a system of classification that is more applicable to prospective payments than is the current classification system. The Department of Health and Human Services (HHS) is required to make a report to Congress outlining specific recommendations by the end of 1985.

Medicaid (Title XIX). Medicaid provides health care benefits to the indigent (based on a means test) and to the disabled (as defined by criteria under the SSI program - Title XVI of the Social Security Act). This program is state administered, financed both by federal and state funds, and the benefits are designed jointly by the federal and state governments. Certain services are mandated federally while others can be developed on an optional basis by states.

Several recent developments will affect mental health services under the Medicaid program. As of January, 1983, senility and organic mental disorders will no longer be counted as part of the 50% ceiling which defines a facility as an Institution for Mental Disease (IMD) and disqualifies it for Medicaid reimbursement. This modification could allow for:

1. Development of nursing homes with specialized units for treatment of the mentally ill, especially those with senile dementia; and

2. Development of alternative staffing patterns allowing for specialized care of psychiatric patients if they cost no more than existing staffing patterns.

Another important development affecting Medicaid is that of home and community-based care waivers. There is an increasing flexibility in the use of federal funding even though the total amount of funding available has been restricted; the home and community based care waivers are one example of this development. Under the waiver, Medicaid funding may be used for development of alternatives to nursing homes and hospitals which cost the same as or less than institutional care. A state agency plan for utilization of these waiver funds must be approved by the Health Care Financing Administration and funds may not be used for room and board costs. Five states have been successful in developing a variety of services such as partial hospitalization, case management, and respite care for the maintenance of the mentally ill in the community.

Supplementary Security Income (Title XVI) and Social Security Disability Insurance (Title II). Payments from these two programs are essential for the maintenance of chronically mentally ill adults in the community. Many mentally ill individuals were terminated from these programs, which has generated a demand for reform measures. Reforms in the SSI/SSDI programs are under consideration by both the executive and legislative branches of the federal government.

The Social Security Administration has established several work groups to review (1) standards for mental disability, (2) process for assessment of ability to work, and (3) documentation required to make a disability claim. The work group reviewing the process for assessment of ability to work has completed its work, and a proposed policy statement with a notice for comment will soon be published in the Federal Register.

The work group reviewing disability standards has recommended that the standards for disability be revised based on the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (3rd Edition). A notice of public rulemaking implementing this recommendation will also be published soon in the Federal Register.

The work group reviewing disability standards had recommended that substance abuse be included as one of the standards for disability, but the Social Security Administration has decided not to publish a separate standard for substance abuse at this time. The federal administration is willing to make changes in the listing of impairments and to test the new standards empirically. Recently, the Social Security Administration negotiated a contract with the American Psychiatric Association to test the reliability and validity of new disability standards and a variety of alternative processes for disability determination. The work group reviewing documentation of disability has just begun its deliberations; its recommendations will be based on the form of the final disability criteria.

Several pieces of legislation affecting disability determination under these programs are under consideration in the current U.S. Congress. One measure, H.R. 3755 sponsored by Rep. Pickle (D-TX) passed the House in April, 1984 and the Senate measure, S.476 sponsored by Senators Levin (D-MI) and Cohen (R-ME), has recently been approved by the Senate. Both measures make improvements in the operation of the disability programs to protect the rights of beneficiaries. Both initiatives would require a finding of medical improvement for cessation of benefits and make provisions for face-to-face hearings for disability determination. However, the Senate version places expiration dates on various provisions and authorizes the development of demonstration projects testing the face-to-face interview concept. Differences may be resolved and final approval given after these bills go to conference committee.*

There seems to be widespread belief across the country that the federal government's moratorium on benefit cessation will be extended. However, the federal government has made no specific plans for such an extension of the moratorium at this writing.

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*The legislation to which Dr. Goldman referred was passed after the NCSL conference. It has been summarized in the description of SSI and SSDI and Appendix C.

STATE MENTAL HEALTH AUTHORITIES: AN EXPENDITURE STUDY

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IN THIS SECTION, DR. GLOVER AND DR. MAZADE DISCUSSED STUDIES WHICH WERE PART OF A NATIONAL ASSOCIATION OF STATE MENTAL HEALTH PROGRAM DIRECTORS (NASMHPD) PROJECT FUNDED BY NIMH. OBJECTIVES OF THESE STUDIES INCLUDED PROVIDING COMPARATIVE COST DATA ON STATE EXPENDITURES FOR MENTAL HEALTH SERVICES, IDENTIFYING CURRENT SOURCES OF FUNDING FOR CARE OF THE MENTALLY ILL, AND STRATEGIES FOR FINANCING A COMPREHENSIVE SYSTEM OF CARE, AND EXPLORATION OF THE EXTENT TO WHICH OTHER STATE GOVERNMENT AGENCIES FUND MENTAL HEALTH SERVICES.

The proportion of funds allocated to operate state mental health hospitals and local mental health services has been a focus of inquiry for many years. Despite the historical interest in the disposition of funds directly controlled by state mental health agencies, to date little information has been accumulated which accurately depicts state mental health agency revenues and expenditures.

The information gap confronting the federal, state and local mental health service systems was expressed clearly by the words of the President's Commission on Mental Health 1979 Task Force Report on cost and financing which observed that:

> "Individual need for mental health services, the cost of providing services, and the costs accrued by not providing mental health care to those in need will continue with or without a valid data base. But the ability to base major policy decisions on sound projections, the ability to use finite resources to the best advantage of the largest number in need, and the ability to continue costs without risking quality depend on the commitment to fill existing data gaps."

This data gap, however, was recently addressed through the completion of two major studies conducted by the National Association of State Mental Health Program Directors (NASMHPD) with financial support from the National Institute of Mental Health (NIMH). The studies are entitled Final Report, Funding Sources and Expenditures for State Mental Health Agencies: Revenue/Expenditure Study Results (1984) and Feasibility Study Results (1984).

Background of Study on State Mental Health Authority Spending

The purposes of the study were multi-dimensional. One purpose of the study was to conduct a thorough, state-by-state review of resources available to and expended by state mental health authorities. The information provided by this study will allow for interstate comparisons, for useful projections by state mental health planners, and could also serve to orient new state mental health commissioners. The focus of the study is an examination of the state mental health agency in terms of the programs that it directly operates and funds, such as the state hospital as well as the monies that flow from the State Mental Health Authority (SMHA) to local programs.

The study attempted to depict expenditures by primary setting, services within the setting, and by the age of groups being served. Expenditures were reflected for children, adolescents, adults and those aged 65 or older. State, federal, local and other revenue sources were identified. Funds accounted for in this project are only those that are under the control of the state mental health agency. The study does not examine other state agency contributions or the revenues and expenditures that are under the control of local programs. For example, expenditure information of community mental health centers (CMHCs) in each state is not included in the study report.

Federal, state, local and other revenue sources feeding into the state mental health authority during a given fiscal year were reported. A breakdown of state funding included: 1) General Revenue Funds appropriated by state legislatures; 2) special revenue items such as the special program in North Carolina which requires the General Assembly to allocate millions of dollars for special services for mentally ill adolescents. (These are non-discretionary monies which the state mental health agency must use in a very specific way.); 3) interdepartmental transfers, e.g., a contract between a Department of Corrections and a state Department of Mental Health to serve adjudicated juveniles with mental health problems; and 4) federal state Medicaid match dollars. Federal funding sources may include Title XVIII, Title XIX, Title XX, as well as Alcohol and Drug Abuse and Mental Health Administration (ADAMHA) federal funds to support, among other things, community mental health centers.

Findings of the Study

On a national basis, state mental health agencies directly controlled and administered over $6 billion (B) dollars in FY 1981. State governments are assuming a substantial amount of the revenues for the operations of state mental health agencies. Approximately $5 B (or 80%) of the total $6.2 B coming to the state mental health agencies is derived from state government sources of which General Revenue Fund constituted nearly 90% ($4.6 B). This indicates that the extent to which state legislatures have control over the amount and level of funding of such services is extremely great. There exists a dependency on the General Assembly for funding to the state mental health agency. Federal program funding is significantly less than it has been in the past.

Formerly, federally-funded CMHCs received funding directly from the federal government. If the CMHCs were operated by the state, then the dollars were received by the SMHA. However, a large percentage of centers were not directly under the SMHA and worked directly with the federal government in receiving their funding. This initial funding to the CMHC gradually diminished after startup over an eight year period. Often, the SMHA was asked to assume funding as federal dollars diminished. With the advent of the Alcohol, Drug Abuse and Mental Health Services (ADM) Block Grant, the SMHA now receives one allotment of federal funds which it then distributes, as it sees fit, to the (originally federally-funded) comprehensive mental health centers. This more limited set of funds and new distribution system is not reflected in the figures of this study, as the Omnibus Reconciliation Act (creating the Block Grants) was passed in August, 1981. The figures of this study were collected during the transition period between direct federal funding and the new Block Grant system.

With regard to federal revenues, the federal Medicaid dollar is, by far, the largest amount of federal money now going to state mental health agencies. While some states do not aggressively attempt to capture federal Medicaid dollars, there are some cases, such as, New York where as much as $258 million (M) is used by the state mental health agency for mental health services. Other federal funds consist of grant monies such as the State Manpower Grants, Community Support Program grants for the chronically mentally ill, and vocational rehabilitation funds.

On the average, states are spending approximately 70-75% of their mental health agency budgets in state mental hospitals as opposed to 25% on community-based programs. Although state hospital populations declined significantly nationwide (from 700,000 in the early sixties to approximately 125,000 presently), deinstitutionalization has had a major impact on treatment modalities and treatment settings. The number of beds available in state mental health hospitals, as well as length of stay in those beds have significantly decreased over the past ten years. However, admissions have quadrupled nationally in this same time period. What this means is that, although the state hospital represents a smaller unit than it did ten years ago, it must have the capacity to serve the increased admissions and discharges over a twelve month period. Consequently, it may be necessary to maintain and to keep the facility available for people who cannot cope at a community level and do not have any alternative. In 1955, state hospitals accounted for 50% of all psychiatric episodes; in 1977, state hospitals accounted for only 9% of all psychiatric episodes. There was an increase from 1.7 million episodes to 6.9 million episodes in out-patient services.

A crucial issue in evaluating the findings of this study involves the methodology for depicting state expenditures in relationship to other states. In developing the profile for a particular state, data including expenditures for state mental hospitals; community programs; research and training; and state administration must be included (see Tables I and II).

The findings of the study indicate that states spent a variable percentage of their resources on state mental hospitals. When comparing per capita expenditures across states, some significant differences are observed. For example, Alaska is forty-seventh (lowest) in actual dollars spent by the state mental health agency for mental health services. However, when reviewing Alaska's per capita expenditures, it moves to the fifth highest. Vermont is forty-sixth in actual dollars spent but ninth in per capita expenditures. Texas, which has the ninth largest actual dollar expenditures, ranks forty-eighth in per capita expenditures. Florida, which has the eighth largest actual dollar expenditure, ranks thirtieth in per capita spending.

Expenditures for Mental Health Services Under the Control of a State Agency Other Than the Mental Health Authority

In addition to the analysis of mental health funding under the control of a state mental health authority, a study designed to investigate other possible sources of funding for mental health services from other state sources was conducted. The study was piloted in the states of Virginia and Tennessee to determine the feasibility of collecting these data in all fifty states.

Due to the variability in the definition of mental illness across states, the study utilized each state mental health agency's definition, rather than developing a standardized one. This was done to increase the possibilities of interagency agreement and cooperation within a state. The state mental health agency can then take the lead in negotiations focusing on responsibility for the mental health system following the identification of other funds affecting mental health programs.

There are several possible sources of funding for mental health services which are provided by state agencies and/or entities other than the identified state mental health agency. These sources include: interdepartmental transfer funds, funds for services operated by another state agency on the grounds of a state mental hospital (such as vocational rehabilitation programs); reimbursements from other state agencies for services provided in a program funded by the state mental health agency (such as Title XX monies for family care services in a community mental health center); programs operated by other state departments which are located within an agency funded by the state mental health authority (special education classrooms located in local mental health agencies); non-mental health facilities having mental health components operated by another state department (such as prison psychiatric units); and funds flowing directly to mental health clients from another state agency, such as medical Assistance payments for services to clients who are eligible for such funds due to a determination that they are "mentally disabled."

The preliminary findings from the two pilot states demonstrated that there are numerous mental health services provided by other state departments and that the state mental health agency should be cognizant of these other programs and funding sources. For example, in Tennessee, state mental health agency expenditures total $70 M. Non-state mental health agency expenditures for mental health services total $79 M and the pilot study identified 33 agencies in the State of Tennessee which have control over these funds. In both states, the amount of non-state mental health agency expenditures for mental health services was equal to or greater than the amount expended by the state mental health agency. If extrapolated on a national basis, total potential estimates by non-state mental health agency mental health services may be as high as $15 B. A more thorough investigation which has been initiated may reveal even higher levels of expenditure by agencies other than the state mental health agency.

Funding for mental health services can be characterized as a series of patches rather than a quilt, since no clear boundaries of responsibility have as yet, been defined. Once all the various actors and funding streams have been identified as it is hoped this study will do, states will have a foundation on which to build a more coordinated mental health system.

The Mental Health System: Issues Highlighted by Results of Study

The question of who is to have policy oversight and to make long-range plans for the state mental health services is a crucial one because of continuing changes in the service population, service settings and financing mechanisms.

One issue which will affect mental health financing is the growing awareness that within the mental health service population, there are a number of subgroups who require varying levels of care. Results of a study conducted by the Department of Mental Health in Colorado (funded by an NIMH research grant) indicated that there was a need to redefine the term "chronic". The term has been recognized by many in the field as too generic, due to the fact that many states encounter a wide diversity among their chronic populations -- i.e., there are old chronics, young chronics, severe chronics, and not so severe chronics.

The need for services to chronically mentally ill persons certainly will represent a significant issue for many states in the future, particularly because of the varying levels of disability. The Colorado study helped mental health professionals to better understand the subgroups of the chronically mentally ill population and where they would be placed in a continuum of care. The two and one-half year study of 10,000 clients yielded four major chronic groups with significantly different needs. These differences have implications for different ways to provide services. Two of the groups were age-dependent. The first group consisted of individuals aged 18 to 24. They are resistant to treatment and are usually adjudicated at some point in time. They tend to be alcohol and/or drug abusers, have a poor employment history, and do not have any permanent residence. Another age-specific group consists of individuals aged 60-65 who require some type of medical treatment. The third group is not age-specific but is a group of individuals with certain basic needs: they cannot feed, clothe, or care for themselves and cannot use public transportation. The fourth group is the psychotic (or thought-disordered) person. Many of these individuals are in state institutions. The differences among these groups indicate a need for different treatment modalities.

It is also necessary to redefine the role of the state hospital. Should the state hospital be a place of asylum (or rest) for those who are most disabled or who cannot function in a community setting? If this is the role of state hospitals, then the meet of the clients and an adequate service delivery system that will need those needs must be addressed. Presently, there are many individuals who have repeatedly entered state institutions. Is there an appropriate service delivery system for these recidivist individuals? There are also severely chronically mentally ill individuals being served in acute care settings. Would these individuals be better served if they were to remain in long-term care facility such as a hospital? Where are the majority of this nation's mentally ill being served? Where would each subgroup best be served?

Although there has been a major shift in where most people are being served, there has not been a corresponding shift in funding under the state mental helth agency. It should be recognized, however, that the role of the state hospital has also changed. Although there have been major efforts to deinstitutionalize, those remaining in the state mental health hospital are primarily those people who are multiple and/or severely handicapped, those who are adjudicated by the courts to such a setting, or those who display very difficult behaviors that the community can no longer tolerate. These clients require extended care and are very expensive to treat. The per capita costs in these facilities are going to be very high, and due to patient management issues, it is often difficult to contract with the community with regard to care for these people.

The interface between a state mental health authority and other agencies is a crucial issue, both in terms of who should be offering certain services and who should be paying for them. An emerging trend may be to use old state hospital grounds to house forensic inmates (not guilty by reason of insanity -- NGRI) or correctional inmates. This is particularly the case in states where inmate populations are growing significantly, where correctional facilities are at capacity, and where there is a noticeable decline in the state mental health beds. As prison overcrowding becomes a key issue, use of underutilized state hospitals for this purpose may increase. Some states are selling mental health facilities and surplus state land and establishing a Mental Health Trust Fund from the monies accrued.

A number of developments which will affect mental health financing at both state and national levels have recently occurred. Under the Block Grant system instituted under the Omnibus Reconciliation Act of 1981, states have more discretion regarding the kinds of programming they can include in their mental health systems. Prevention, consultation, education, and staff training are components of a mental health system that should be continued.

At the national level, recent developments will affect financing of both hospital and community care for the mentally ill. State psychiatric hospitals will be the next group to institute Diagnostic Related Groupings (DRGs). DRGs identify certain patient types and particular services. These services are funded according to the diagnosis, not according to length of treatment or actual expenditures. This system could have major implications for the state hospitals, particularly with regard to extended lengths of stay for clients with chronic mental health and other health problems. Thus, the rate of reimbursement for the diagnosis does not account for all costs incurred, particularly when extended lengths of stay are required.

In addition, Medicaid waivers are now being implemented for community alternatives to institutionalization for mental illness. Prior to the waiver, Medicaid traditionally served as a disincentive for community-based, non-hospital oriented, non-medical services. Medicaid focused on physician-controlled, physician-prescribed treatment. The waiver allows states to determine community-based alternatives to institutionalization. There are several states now using the waiver. Although not foolproof, the program allows states to choose this as a viable way to fund alternatives to hospitalization. There are stringent restrictions with regard to use of the waiver -- e.g., one cannot exceed the cost of institutionalization for the client who is diverted. The waiver is now being used predominately for the developmentally disabled populations and the elderly, though some states (such as Colorado) are using the waiver for care of mentally ill persons.

TABLE I

STATE MENTAL HEALTH AUTHORITIES
AN EXPENDITURE STUDY

TABLE I: FY'81 SMHA CONTROLLED MENTAL HEALTH PROGRAM EXPENDITURES: BY POPULATION RANK

STATE	POP RANK	STATE MENTAL HOSPITALS	%	COMMUNITY-BASED PROGRAMS	%	RESEARCH & TRAINING	%	SMHA ADMINISTRATION	%	TOTAL SMHA MH EXPENDITURES	TOTAL RANK
CALIFORNIA	1	$ 210,894,000	31.0%	$ 453,322,000	66.6%	$ 381,000	0.1%	$ 15,677,000	2.3%	$ 680,274,000	2
NEW YORK	2	983,663,000	83.9	127,268,181	10.9	22,129,000	1.9	38,717,000	3.3	1,171,777,181	1
TEXAS	3	135,526,466	70.9	43,144,792	22.6	3,164,111	1.7	9,233,835	4.8	191,069,294	9
PENNSYLVANIA	4	374,702,000	77.9	91,312,378	19.0	12,368,000	2.6	2,729,000	0.6	481,111,378	3
ILLINOIS	5	145,110,400	71.2	48,804,500	24.0	[9,170,300]	UA	9,800,000	4.8	203,714,900	7
OHIO	6	167,585,383	62.8	82,167,074	30.8	3,222,757	1.2	13,692,812	5.1	266,668,026	5
FLORIDA	7	125,775,820	62.6	73,767,967	36.8	UA	UA	1,217,550	0.6	200,761,337	8
MICHIGAN	8	190,500,000	63.7	100,400,000	33.6	UA	UA	8,000,000	2.7	298,900,000	4
NEW JERSEY	9	110,281,077	64.1	58,310,423	33.9	250,028	0.1	3,128,439	1.8	171,969,967	10
NORTH CAROLINA	10	103,134,036	69.7	44,183,902	29.9	118,978	0.1	463,846	0.3	147,900,962	11
MASSACHUSETTS	11	109,819,171	52.5	93,884,185	44.9	UA	UA	5,418,797	2.6	209,122,153	6
INDIANA	12	69,509,828	67.3	31,982,806	31.0	229,441	0.2	1,485,370	1.4	103,207,345	17
GEORGIA	13	125,316,360	90.7	9,328,697	6.8	0	0.0	3,460,179	2.5	138,105,236	12
VIRGINIA	14	99,493,470	83.2	16,163,342	13.5	1,900,000	1.6	2,056,152	1.7	119,612,964	13
MISSOURI	15	70,255,866	60.6	41,709,325	36.0	448,310	0.4	3,425,291	3.0	115,838,792	15
WISCONSIN	16	22,024,045	20.7	83,406,822	78.5	UA	UA	795,082	0.7	106,225,949	16
TENNESSEE	17	65,219,760	79.6	13,770,381	16.8	797,468	1.0	2,195,977	2.7	81,983,586	20
MARYLAND	18	83,910,873	70.3	31,765,922	26.6	3,064,865	2.6	542,477	0.5	119,284,138	14
LOUISIANA	19	59,986,017	74.6	17,028,207	21.2	846,285	1.1	2,539,855	3.2	80,400,364	21
WASHINGTON	20	36,289,052	48.7	36,093,966	48.5	6,980	0.0	2,099,182	2.8	74,489,079	23
MINNESOTA	21	39,730,081	57.2	29,456,236	42.4	UA	UA	334,376	0.5	69,520,693	25
ALABAMA	22	61,814,145	79.5	12,231,183	15.7	UA	UA	3,719,581	4.8	77,764,909	22
KENTUCKY	23	32,069,858	59.3	20,638,943	38.2	0	0.0	1,381,661	2.6	54,090,462	28
SOUTH CAROLINA	24	65,923,065	68.7	18,303,610	19.1	6,014,015	6.3	5,657,017	5.9	95,897,707	19
CONNECTICUT	25	66,933,907	67.8	23,218,799	23.5	3,455,258	3.5	5,178,556	5.2	98,786,520	18
OKLAHOMA	26	44,707,942	65.8	20,059,335	29.5	UA	UA	3,156,971	4.6	67,924,248	26
IOWA	27	22,578,920	98.1	NR		327,500	1.4	115,500	0.5	23,021,920	41
COLORADO	28	43,576,719	62.3	24,645,719	35.2	668,118	1.0	1,106,724	1.6	69,997,280	24
ARIZONA	29	16,485,326	59.3	10,858,588	39.0	356,175	1.3	117,845	0.4	27,817,934	37
OREGON	30	31,199,500	57.2	19,619,068	36.0	UA	UA	3,727,206	6.8	54,545,774	27
MISSISSIPPI	31	31,529,309	91.2	1,954,511	5.7	3,023	0.0	1,084,413	3.1	34,571,256	32
KANSAS	32	35,377,659	85.8	4,517,222	11.0	1,081,696	2.6	258,246	0.6	41,234,823	29
ARKANSAS	33	16,381,584	42.5	15,496,905	40.2	UA	UA	6,654,517	17.3	38,533,006	30
WEST VIRGINIA	34	24,298,244	63.1	13,959,355	36.3	UA	UA	241,982	0.6	38,499,581	31
NEBRASKA	35	18,094,780	77.9	4,168,388	17.9	UA	UA	966,981	4.2	23,230,149	40
UTAH	36	9,990,922	49.5	9,689,576	48.0	95,666	0.5	411,298	2.0	20,187,462	42
NEW MEXICO	37	22,535,400	71.9	7,567,900	24.2	UA	UA	1,217,753	3.9	31,321,053	35
MAINE	38	20,889,313	74.1	6,458,967	22.9	120,466	0.4	730,721	2.6	28,199,358	36
HAWAII	39	7,153,044	41.0	9,473,829	54.3	130,954	0.8	698,800	4.0	17,456,627	45
RHODE ISLAND	40	28,355,483	83.2	5,170,895	15.2	256,400	0.8	297,317	0.9	34,079,995	33
IDAHO	41	7,378,200	57.5	4,922,900	38.4	95,500	0.7	434,400	3.4	12,831,000	48
NEW HAMPSHIRE	42	25,124,556	75.7	6,405,533	19.3	88,906	0.3	1,575,215	4.7	33,194,210	34
NEVADA	43	7,496,936	41.2	10,241,084	56.3	44,742	0.2	410,733	2.3	18,193,495	44
MONTANA	44	11,488,567	59.3	7,437,599	38.3	287,168	1.5	175,463	0.9	19,388,797	43
SOUTH DAKOTA	45	9,162,618	78.3	2,280,984	19.5	71,647	0.6	186,216	1.6	11,701,465	49
NORTH DAKOTA	46	15,825,966	63.3	8,640,463	34.6	UA	UA	529,898	2.1	24,996,318	39
DELAWARE	47	22,379,403	85.5	2,481,600	9.5	1,138,485	4.3	185,900	0.7	26,185,388	38
VERMONT	48	8,749,041	52.1	7,789,493	46.3	UA	UA	268,578	1.6	16,807,112	46
WYOMING	49	8,620,424	76.1	2,640,000	23.3	0	0.0	74,535	0.7	11,334,959	50
ALASKA	50	9,928,800	66.0	4,073,700	27.4	UA	UA	884,700	5.9	14,887,200	47
TOTAL:	50	$4,054,375,434	66.5%	$1,812,126,740	29.7%	$63,159,634	1.0%	$ 168,760,148	2.8%	$6,098,422,157	50

TABLE I.I: AVERAGE FY'81 SMHA CONTROLLED MENTAL HEALTH PROGRAM EXPENDITURES: BY POPULATION RANK

POP RANK	STATE MENTAL HOSPITALS	%	COMMUNITY-BASED PROGRAMS	%	RESEARCH AND TRAINING	%	SMHA ADMINISTRATION	%	TOTAL SMHA MH EXPENDITURES
1-10	$ 254,697,217	66.8%	$ 112,270,122	29.4%	$ 5,947,698	1.6%	$ 10,285,988	2.7%	$ 381,416,595
11-20	74,180,454	64.6	37,512,448	32.7	911,531	0.8	2,401,736	2.1	114,823,951
21-30	42,502,847	66.5	19,882,275	31.1	1,803,511	2.8	2,449,544	3.8	63,937,545
31-40	21,460,574	69.8	7,845,725	25.5	281,368	0.9	1,256,203	4.1	30,731,321
41-50	12,596,451	66.5	5,681,335	30.0	246,350	1.3	482,564	2.5	18,932,795

UA = SERVICES PROVIDED, BUT EXACT EXPENDITURES UNALLOCATABLE
NR = SMHA NOT RESPONSIBLE FOR COMMUNITY-BASED PROGRAMS IN FY'81
[] = FUNDS IDENTIFIABLE, BUT UNALLOCATABLE FROM MENTAL HOSPITALS AND COMMUNITY PROGRAM EXPENDITURES

TABLE II

STATE MENTAL HEALTH AUTHORITIES PER CAPITA EXPENDITURES

TABLE II: SMHA PER CAPITA CONTROLLED FY'81 MENTAL HEALTH PROGRAM EXPENDITURES: BY POPULATION RANK

STATE	STATE POP RANK	STATE MENTAL HOSPITALS	%	COMMUNITY-BASED PROGRAMS	%	RESEARCH & TRAINING	%	SMHA ADMIN	%	TOTAL SMHA MH EXPEND	PERCAP RANK
CALIFORNIA	1	$ 8.90	31.0%	$ 19.15	66.6%	$ 0.02	0.1%	$ 0.67	2.3%	$ 28.74	13
NEW YORK	2	56.02	83.9	7.25	10.9	1.28	1.9	2.21	3.3	66.74	1
TEXAS	3	9.52	70.9	3.03	22.6	0.22	1.7	0.65	4.8	13.43	48
PENNSYLVANIA	4	31.58	77.9	7.70	19.0	1.04	2.6	0.23	0.6	40.55	3
ILLINOIS	5	12.70	71.2	4.27	24.0	[0.72]	UA	0.86	4.8	17.83	38
OHIO	6	15.52	62.8	7.61	30.8	0.30	1.2	1.27	5.1	24.70	18
FLORIDA	7	12.90	62.6	7.57	36.8	UA	UA	0.12	0.6	20.60	30
MICHIGAN	8	20.57	63.7	10.84	33.6	UA	UA	0.86	2.7	32.27	10
NEW JERSEY	9	14.97	64.1	7.92	33.9	0.03	0.1	0.42	1.8	23.35	24
NORTH CAROLINA	10	17.53	69.7	7.51	29.9	0.02	0.1	0.08	0.3	25.15	16
MASSACHUSETTS	11	19.14	52.5	16.36	44.9	UA	UA	0.94	2.6	36.45	6
INDIANA	12	12.66	67.3	5.83	31.0	0.04	0.2	0.27	1.4	18.80	34
GEORGIA	13	22.94	90.7	1.71	6.8	0.00	0.0	0.63	2.5	25.28	15
VIRGINIA	14	18.61	83.2	3.02	13.5	0.36	1.6	0.38	1.7	22.37	28
MISSOURI	15	14.29	60.6	8.48	36.0	0.09	0.4	0.70	3.0	23.56	23
WISCONSIN	16	4.68	20.7	17.72	78.5	UA	UA	0.17	0.7	22.57	26
TENNESSEE	17	14.21	79.6	3.00	16.8	0.17	1.0	0.48	2.7	17.86	37
MARYLAND	18	19.90	70.3	7.53	26.6	0.73	2.6	0.13	0.5	28.29	14
LOUISIANA	19	14.26	74.6	4.05	21.2	0.20	1.1	0.60	3.2	19.12	33
WASHINGTON	20	8.78	48.7	8.73	48.5	0.00	0.0	0.51	2.8	18.02	36
MINNESOTA	21	9.75	57.2	7.23	42.4	UA	UA	0.09	0.5	17.06	40
ALABAMA	22	15.87	79.5	3.14	15.7	UA	UA	0.96	4.8	19.97	31
KENTUCKY	23	8.76	59.3	5.64	38.2	0.00	0.0	0.38	2.6	14.78	44
SOUTH CAROLINA	24	21.12	68.7	5.86	19.1	1.93	6.3	1.81	5.9	30.72	12
CONNECTICUT	25	21.54	67.8	7.47	23.5	1.11	3.5	1.67	5.2	31.79	11
OKLAHOMA	26	14.78 *	65.8	6.63	29.5	UA	UA	1.04	4.6	22.45	27
IOWA	27	7.75	98.1	NR	NR	0.11	1.4	0.04	0.5	7.90	50
COLORADO	28	15.08	62.3	8.53	35.2	0.23	1.0	0.38	1.6	24.22	20
ARIZONA	29	6.06	59.3	3.99	39.0	0.13 *	1.3	0.04	0.4	10.23	49
OREGON	30	11.85	57.2	7.45	36.0	UA	UA	1.42	6.8	20.72	29
MISSISSIPPI	31	12.51	91.2	0.78	5.7	0.00	0.0	0.43	3.1	13.72	46
KANSAS	32	14.97	85.8	1.91	11.0	0.46	2.6	0.11	0.6	17.45	39
ARKANSAS	33	7.16	42.5	6.78	40.2	UA	UA	2.91	17.3	16.85	42
WEST VIRGINIA	34	12.46	63.1	7.16	36.3	UA	UA	0.12	0.6	19.75	32
NEBRASKA	35	11.53	77.9	2.66	17.9	UA	UA	0.62	4.2	14.80	43
UTAH	36	6.84	49.5	6.63	48.0	0.07	0.5	0.28	2.0	13.82	45
NEW MEXICO	37	17.30	71.9	5.81	24.2	UA	UA	0.93	3.9	24.04	22
MAINE	38	18.57	74.1	5.74	22.9	0.11	0.4	0.65	2.6	25.07	17
HAWAII	39	7.41	41.0	9.82	54.3	0.14	0.8	0.72	4.0	18.10	35
RHODE ISLAND	40	29.94	83.2	5.46	15.2	0.27	0.8	0.31	0.9	35.98	8
IDAHO	41	7.82	57.5	5.22	38.4	0.10	0.7	0.46	3.4	13.59	47
NEW HAMPSHIRE	42	27.29	75.7	6.96 *	19.3	0.10	0.3	1.71	4.7	36.06	7
NEVADA	43	9.37	41.2	12.79	56.3	0.06	0.2	0.51 *	2.3	22.73 *	25
MONTANA	44	14.62	59.3	9.45	38.3	0.37	1.5	0.22	0.9	24.66	19
SOUTH DAKOTA	45	13.26	78.3	3.30	19.5	0.10	0.6	0.27	1.6	16.94	41
NORTH DAKOTA	46	24.25	63.3	13.24	34.6	UA	UA	0.81	2.1	38.30	4
DELAWARE	47	37.65	85.5	4.16	9.5	1.91	4.3	0.31	0.7	44.05	2
VERMONT	48	16.91	52.1	15.03	46.3	UA	UA	0.53	1.6	32.47	9
WYOMING	49	18.36	76.1	5.62	23.3	0.00	0.0	0.16	0.7	24.14	21
ALASKA	50	24.46	66.0	10.14	27.4	UA	UA	2.45	6.6	37.05	5
AVERAGE:	50	$ 16.30	67.1%	$ 7.22	29.7%	$ 0.34	1.4%	$ 0.69	2.8%	$ 24.30	50

TABLE II.I: AVERAGE PER CAPITA SMHA CONTROLLED M.H. PROGRAM EXPENDITURES: BY POPULATION RANK

STATE POP RANK	STATE MENTAL HOSPITALS	%	COMMUNITY-BASED PROGRAMS	%	RESEARCH & TRAINING	%	SMHA ADMIN	%	TOTAL SMHA MH EXPEND
1 - 10	$ 20.02	68.3%	$ 8.28	28.2%	$ 0.41	1.4%	$ 0.74	2.5%	$ 29.34
11 - 20	14.95	64.3	7.64	32.9	0.20	0.9	0.46	2.1	23.23
21 - 30	13.26	66.3	6.22	31.1	0.58	2.8	0.78	3.8	19.98
31 - 40	13.87	69.5	5.27	26.4	0.17	0.9	0.71	3.6	19.96
41 - 50	19.40	66.9	8.59	29.6	0.38	1.3	0.74	2.6	29.00

UA = SERVICES PROVIDED, BUT EXACT EXPENDITURES UNALLOCATABLE
NR = SMHA NOT RESPONSIBLE FOR COMMUNITY-BASED PROGRAMS IN FY'81
[] = FUNDS IDENTIFIABLE, BUT UNALLOCATABLE FROM STATE HOSPITAL AND COMMUNITY PROGRAM EXPENDITURES
* = MEDIAN VALUES

PRIVATE THIRD PARTY PAYMENT AS A SOURCE FOR MENTAL HEALTH CARE

Allen Feezor

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MR. FEEZOR PROVIDED A COMPREHENSIVE VIEW OF CURRENT COVERAGE OF MENTAL HEALTH SERVICES BY PRIVATE INSURANCE, PROBLEMS WITH CURRENT COVERAGE, AND FUTURE POLICY DECISIONS WHICH FOCUS ON STATE RESPONSIBILITIES.

Private Third Party Payment as a Source for State/Federal Shortfalls in Mental Health Care

By some estimates, Federal support for mental health programs will decrease as much as 30% between FY 1983 and 1986. The impact of federal cutbacks has been accentuated by tight fiscal situations faced by most states during this same period. While an upturn of the economy in 1984 may bring some fiscal relief at the federal and state levels, mental health programs are not likely to benefit from this upturn. Absent major policy changes, the federal government's obsession with budget deficits, defense buildups, and entitlements translate to continued downward pressure on the discretionary funding programs of which mental health is one. At the state level, concerns about infrastructure, revitalization of education, industry recruitment, long overdue pay raises for state employees, and funding of existing Medicaid benefits will readily absorb any state tax dollars coming on line as the economy picks up.

Private Coverage: Background

The present structure of mental health benefits provided by non-profit Blue Cross and Blue Shield Plans, commercial insurance companies, and public third-party payers (most notably, Medicare and Medicaid) basically emerged after World War II. At that time, health benefit structures responded to the decision of general hospitals to open short-term psychiatric units, and to the growth in the supply of physicians specializing in office-based psychiatry. Before then, psychiatry focused on long-term institutional care provided in either state or private hospitals, with patients sorted by their ability to pay.

Current Private Coverage

Current institutional mental health benefits of most third-party payers focus on short-term care in general hospital psychiatric beds or in private psychiatric hospitals. Reimbursement is now often made to state institutions as well. This coverage is often less extensive than inpatient benefits for non-psychiatric or medical/surgical admissions in terms of both the duration of coverage and the waiting period before the reinstatement of benefits.

Still greater restrictions exist under mental health benefits for coverage of outpatient care. Outpatient coverage, for instance, is often provided under supplemental or major medical schemes. These also usually involve patient cost sharing through deductibles, co-payments, co-insurance, maximum visit allowances, or total dollar limits on coverage.

Private Coverage: Trends

A recent General Accounting Office (GAO) study in February, 1983, found a surprisingly positive trend toward coverage of mental disorders within the private sector. About one-third of the private plans cover between 30 and 70 days of inpatient mental health expenses -- frequently with some additional days covered under major medical. Another third provided full coverage for 120 days or more. The remaining third covered expenses at 80 to 100 percent for an unlimited number of days subject to a dollar maximum.

Outpatient mental health benefits were generally covered under major medical, albeit with co-insurance ranging from between 20% and 50%. Over one-fourth of the private plans surveyed offered catastrophic protection for outpatient mental health benefits.

More recent surveys of businesses and organizations which are representative of large financial, service, and industrial employers have shown:

- 92% of the plans provide for outpatient psychiatric coverage;
- 72% of the plans which provide outpatient psychiatric coverage place no limits on the maximum number of visits;
- 57% provide the same coverage for routine services of inpatient psychiatric care as for other confinements;
- 69% provide the same coverage for in-hospital doctor expenses for psychiatric care as for other confinements;
- 47% of the plans covering outpatient psychiatric expenses have no dollar maximum other than that for the overall major medical plan;
- 30% of the plans have alcohol and drug assistance programs.

These figures suggest that: 1) there may not be as many new dollars generated from legislative mandates of fuller nervous and mental coverages; and 2) such mandates may more severely impact marginal, small groups and/or individuals for whom affording any health coverage at all is a real concern.

Problems*

Until the 1970's, few significant alternatives existed to short-term institutional care and office-based psychotherapy. Hence, the original design of mental health coverages was not governed by a direct assessment of the mental health service needs of the population. In addition, little dissatisfaction with these arrangements had been expressed and often these policy trends had been amplified through collective bargaining agreements.

Another potential problem concerned the inability of insurers and other payers to make payment only for needed and appropriate care under the new mental health coverages. Normally, insurers control utilization for need and appropriateness through utilization review programs or "medically necessary criteria." These programs use criteria that relate diagnosis to significant patient characteristics to identify utilization that departs from norms. Insurers then review exceptional cases for need and appropriateness before making payment. Thus, utilization review programs help payers predict and control costs.

However, until the mid '70s, little "hard" criteria or mechanisms existed to review mental health benefit utilization for appropriateness and need -- particularly for non-institutional care. Also, the administration of claims was further complicated by the inherent vagueness of many mental health diagnoses and prognoses and by confidentiality limits on the payer's access to case data. Consequently, when third-party payers initiated coverage of mental health services, they could not systematically review claims submitted by participating providers for covered services rendered to eligible members. To help predict and control costs, the payers relied on the structural limits built into the benefits themselves. This arrangement inevitably placed significant financial burdens on certain patients and restricted their access to needed care. Nevertheless, utilization review even for non-mental health services was primitive. Cost-containment was not a pressing issue and the existing arrangement adequately satisfied consumers, providers, and payers alike.

Today, however, structural and administrative problems with mental health benefits are recognized and are of significant concern. Changes in the organization, supply, and delivery of mental health resources, rising health care costs, shifting consumer benefit preferences, changing patterns of mental health service utilization, and diminishing economic strength have now aggravated these problems.

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*A substantial portion of this section was developed by Howard A. Berkowitz, Blue Cross-Blue Shield Association.

Another traditional concern is the rate of growth of the mental health community. Today, more than 1,500 general hospitals have short-term psychiatric beds and about 28,000 physicians specialize in psychiatry. Between 1963 and 1973, psychiatry was the third fastest growing specialty in the United States. Since the distribution of these resources does not always correspond to consumer needs, many underserved areas still exist -- particularly in rural communities, small towns, and poverty districts of cities. Consequently, in some areas low supply creates underutilization of benefits. However, in many affluent metropolitan areas, excess capacity can lead to overutilization of benefits. Washington, D.C. is a classic example of this overutilization which can result in the delivery of unneeded and inappropriate care. Such delivery can threaten the solvency of the benefit programs and, more regrettably, deflect public and private dollars away from more needy individuals.

In addition to the extraordinary growth in traditionally covered mental health resources, the nature of mental health resources has changed in important ways. Non-traditional treatment settings and new mental health personnel have emerged and multiplied.

By the early 1960s, new psychotropic drugs and psychotherapies enabled federal and state policy to begin weaning long-term chronic mental patients from their dependence on total institutional care. The policy was conceived to help these patients grow more autonomous and oriented to reality and to economize expenditures in public mental health budgets. Therefore, during the last twenty years, government has invested heavily in new community-based treatment settings and in staff training programs for non-physician mental health professionals for these community based settings.

These new policies created an immense supply of non-traditional mental health settings (i.e., community mental health centers and other community-oriented settings) that gave patients the greatest possible exposure to normal community life. This, in turn, has created a large cadre of non-physician manpower -- practicing diverse disciplines such as: crisis intervention, screening, diagnosis, counseling, rehabilitation, outreach, consultation, education, patient advocacy, alcohol and drug abuse treatment, and therapies to enhance social, occupational, and recreational skills. There are as many as 100,000 who represent many levels of training, education, and qualifications; these individuals now comprise about one-half of all caregivers in the mental health field.

Modifications in mental health benefit structures must include coverage for all existing mental health resources in the most cost-effective way. However, reforming the system involves more than a simple, expanded definition of reimbursable providers of expansion of benefits. These non-traditional resources have important contributions to make to the needs of the covered population. Benefit structures and, administration and delivery systems, must be designed to cost-effectively draw from these non-traditional resources and then tested. In addition, the needs and spending policies of existing institutions need to be critically examined. As one student of mental health policy notes, "It is not difficult . . . to understand the reluctance of insurers to expand the definition of reimbursable providers of mental health care in any open-ended way because such personnel significantly outnumbers the approximately 28,000 psychiatrists. If there is anything we know well in the health services field, it is that the availability of supply in the absence of fee barriers dramatically affects demand" (Mechanic, 1980).

Another challenge threatening mental health coverage is the growth in the use of mental health resources for more than the treatment of mental illness. Resources are also used for support in managing the problems of daily life, for self-fulfillment and for self-realization. Much of this care can promote a sense of wholeness which may help prevent more conventionally defined illness; but, without a reliable and responsible process to review utilization for real need and appropriateness, mental health benefit programs can spend scarce financial resources -- public or private -- on non-essential demand. This trend places in jeopardy future financial access to mental health services for persons in greater need.

Another issue related closely to problems with utilization and utilization review is confidentiality. This issue has two perspectives. The first, concerns the practical complications of utilization review created by limits imposed by confidentiality requirements on the payer's access to case data. The other side of this issue, and perhaps more disturbing, is the submission of health insurance claims by therapists with inaccurate diagnostic data, rationalized by concerns to protect the confidentiality of patient disclosures (Scharfstein, 1980). This practice can erode the confidence of the purchasers of group health benefits in mental health coverages.

Finally, changing consumer preferences in health insurance coverages, rising health care costs, and unfavorable economic conditions have begun to erode marketplace support for mental health benefits. As health care costs continue to rise and consume an ever greater percent of the gross national product (now nearly 10%), purchasers of group health benefits can be expected to contain the costs of their coverages by reducing or eliminating the benefits of lesser preference. In some cases, they apply the savings to add new coverages of greater popularity. Coverage of basic hospitalization and related medical, surgical, and diagnostic services are favored because they involve high cost services that intervene in life-threatening situations.

New areas of coverage gaining increasing popularity include certain preventive services, well-baby, dental, and vision care. Recent trends toward reducing costs in health benefit programs and allocating available funds to more popular coverages do not bode well for mental health benefits, nor existing health benefits. Trends toward higher deductibles and higher cost for all health benefits are accelerating in the name of cost-containment.

Thus, structural and administrative problems are having a cumulative effect on mental health benefits. To some, costs seem disproportionate to the perceived value and there appears to be an increasing loss of interest in mental health coverages per se.

Many of the cost dilemmas result from problems within the administrative structure. To resolve these problems, it is important that organizations and individuals with responsibility for mental health policy work in concert with concerned state officials. They must take necessary steps to fully define the problems facing the delivery and financing of mental health care in order to develop, test, evaluate, and disseminate solutions.

Some Policy Considerations for Financing Mental Health Care

As noted earlier, it is most appropriate that concerned state officials critically examine the question of how mental health will be delivered in the future. There is every indication that the decision rests largely with state officials. The following are some issues, questions, and suggestions which might be helpful to state officials in their deliberations. These incorporate some of the concerns of private insurers. This list represents only a few of the policy issues that need to be debated.

Coverage of Non-Insured. Even if full mental coverage existed in every health plan, there is likely to be a residual population of either (a) uninsured or (b) chronically or severely mentally disabled for whom the state will have to bear the expense. How large or small this population is, how to most effectively and efficiently care for this population and how to most equitably finance such treatment (taxes, insurance premiums, etc.) is of major import.

Varying Levels of Need. A stronger public consensus is needed to understand the difference between serious mental illness (and treatment thereof) and other "social" problems, such as learning disabilities, behavioral modification, etc. Similarly, a stronger differentiation must be made between mental illness or mental disease and the achievement of maximum human potential, such as happiness, social well-being, and marital/family counseling.

Continued Growth in Mental Health Claims. Mental illness, in the narrower sense, is insurable. While some "offset effects" may occur, mental health coverage can be expected to rise to between 7% and 10% of total claims expense.

Utilization of Coverage. Only about 1% of the persons covered account for this added 7% to 8% of cost. While this clearly indicates how important mental health coverage is for these individuals, it also suggests that other benefits -- dental, prenatal, eye care -- may be a more equitable use of marginal health benefit dollars. Also, some studies point to mental health treatment as being directed largely at middle and upperclass recipients regardless of coverage. If so, this raises serious equity questions.

Distribution of Insurance Cost. The impact of these additional costs (7%) are likely to fall most acutely on new employer groups, the small group employer, or individuals for whom existing health coverage is already prohibitively expensive. As noted, larger employer groups tend to have better mental health coverage. Yet most of the new jobs developed are low wage service positions or positions created jobs created by new small employers -- groups who often cannot afford existing coverages.

Cost-Containment Pressures in Public and Private Sectors. Policymakers should expect substantial opposition from business and industry. Nationwide, about 38% of labor cost goes to benefits. Health care benefit increases have become a number one target for business. In 1983 alone, 40 carriers in the federal employees health insurance program reduced existing mental health coverages under pressure from Office of Personnel Management (OPM) to hold down rate increases. Legislation to extend existing benefits to more individuals, laid-off employees, or the marginally employed may compete for employee benefit dollars. And states concerned about remaining competitive with other states in the industry market may need to examine further mandates.

Insurer opposition may be expected in part because anything which suggests increasing the scope and cost of coverage is occurring precisely when intense pressure is on insurers to find ways of effectively holding down the cost of existing coverages. Also, legislative mandates are viewed as ad hoc responses to political pressure by vested interest groups without careful examination of the total health care needs against the limited dollars available for health.

State Responsibilities. A thorough examination and understanding of the inter-relationships between a state's mental health needs and its licensure and certification standards (professional and facility) is critical prior to expansion and design of benefits or further commitment of public monies. Expansion of benefits often has the unwanted effect of inducing excessive capacity or attracting expensive practitioner/facility development at the expense of some existing institutions and providers.

- States should fully assess what benefits are already being provided.
- States should lead by example through inclusion of coverages in their own employee and Medicaid plans.
- Strong peer review, concurrent review.
- Mental health programs should be collapsed into and become an integral part of a total state health plan.

In conclusion, rather than repeat the same costly mistakes in mental health coverage that have been made in other medical coverage under the rubric of "equity", more innovation in delivery, benefit design, provider distribution, utilization review, peer review, concurrent review and prior approval should be employed.

MENTAL HEALTH SERVICES AND INSURANCE IN CALIFORNIA

Margaret Kelly

MARGARET KELLY, DIRECTOR, MEDICAL REVIEW DIVISION, BLUE CROSS OF CALIFORNIA, IS A NURSE AND PREVIOUSLY SERVED IN AN ADMINISTRATIVE POSITION WITH AN HMO IN ILLINOIS. SHE DISCUSSES THE PRIVATE INSURER'S VIEW OF MENTAL HEALTH SERVICES INCLUDING AN INNOVATIVE, NEW SUBSTANCE ABUSE BENEFIT, THE VARIETY OF BLUE CROSS MENTAL HEALTH BENEFIT PACKAGES AVAILABLE IN CALIFORNIA, AND SOME EMERGING CONCERNS OF INSURERS ABOUT CHANGES IN MENTAL HEALTH SERVICE DELIVERY.

The Insurance Industry: Innovative Approaches

Blue Cross and Blue Shield recently released nationwide a substance abuse rehabilitation benefit designed as an additional option to be included in the standard benefit package of the matrix contract to national account members. This benefit does not replace but is a supplement to the substance abuse benefit currently available as part of the matrix psychiatric benefit. The substance abuse rehabilitation benefit provides coverage for institutionally-based rehabilitative treatment for alcoholism and drug abuse provided in both hospital and non-hospital settings.

The benefit maximums of this package are designed to encourage utilization of the most appropriate, least costly care: inpatient hospital care is covered for a maximum of 60 days per lifetime. A maximum of 180 days per lifetime of residential rehabilitation is also included. These days are in addition to inpatient hospital days, but each residential rehabilitation day reduces available outpatient days by one. Coverage is provided for a maximum of 180 days per lifetime for outpatient care. This package is designed so that a subscriber who has begun with a period of inpatient or residential care could move to less intensive (and generally less costly) treatment. Coverage of costly hospital days are limited and incentives are provided to encourage utilization of less costly and less restrictive settings.

Current Reimbursement in Blue Cross of California: Psychiatric, Alcohol and Substance Abuse Social Model Programs

In California, Blue Cross is utilizing the concept of eligible providers. Originally, the concept encompassed only physicians, psychiatrists, and hospitals but has been expanded to include psychologists, licensed clinical social workers, psychiatric nurse practitioners, and marriage, family and child counselors (MFCCs). There are a variety of contracts covering a wide range of outpatient mental health treatment. Contract maximums vary in outpatient coverage from 10 visits to an unlimited number of visits per year, with reimbursement maximums ranging from $250 to an unlimited dollar amount per year. California offers a greater variety of contracts for outpatient care than other areas of the country. There are also a variety of contracts covering inpatient treatment, varying from 21 to 365 day annual maximums, with a reimbursement rate of 50% to 100% of billed services. With these ranges, it is evident that there is great variability in what is covered by individual contracts.

In 1976, Blue Cross of California established its currently running program for psychiatric day treatment for alocholism and alcohol abuse. Under this program, benefits are extended to provide partial day hospitalization coverage in a selected number of hospitals. The current benefit allows for a trade-off system. This means that two partial day visits are equal to one inpatient benefit day, thus encouraging utilization of the less costly day visit mode. Professional physician fees for the partial day visits are paid at the same rate as inpatient to encourage the professional community to utilize the service. Provider selection criteria must demonstrate that acute admissions to a (generally more expensive) inpatient hospital setting are being avoided or that lengths of stay for necessary acute admissions are being shortened. The program is limited to day treatment only; overnight care is not covered. Blue Cross has found that the use of the program by the provider community (there are currently 12 hospitals in the program) is very low. A poor response was obtained on a questionnaire sent to users to investigate possible reasons for low utilization of this new benefit and the need to either redesign or discontinue the program. This is perhaps an indication to Blue Cross that interest in innovative programs of this sort is low.

The most recent innovation of Blue Cross of California has been contracting agreements with Residential Social Model Substance Abuse Treatment Programs. Prior to these contracts, Blue Cross had a very difficult time evaluating programs and determining whether or not they should be reimbursed. One hundred percent of the providers solicited for this program (13 providers total) responded favorably to participation and developed a credentialing program to enable evaluation by Blue Cross. Twelve facilities met established criteria and were approved. One program could not be authorized for reimbursement through Blue Cross because they had already been licensed as a Skilled Nursing Facility. Criteria for Blue Cross reimbursement of services rendered included: licensing by the state (Health & Safety License) as a social rehabilitation facility; a treatment program directed by a qualified physician; a Blue Cross-approved program protocol; and rates approved by Blue Cross. All the facilities must meet criteria set for medical models as well. The average length of stay in the residential social programs runs approximately 28 days (validation for the fourth week is required). The charges for these programs range from $165-$195 per day; this rate compares very favorably to the average charge in an acute setting of $350 per day.

Third Party Payor Concerns

There are various concerns related to evaluating newly changed benefit structures in the insurance industry. The original approach to coverage of mental health services contained potential problems that were initially unrecognized by the private insurers. Several issues of concern include:

Program Assessment. It is very difficult for Blue Cross to evaluate the quality of new programs, particularly those that utilize innovative approaches to providing mental health care. Blue Cross does not have the resources to evaluate all new programs which seek coverage and credential approval through them. Many of these provider groups represent professionals with a variety of credentials, backgrounds, and objectives. Blue Cross, must, therefore, rely upon the state to develop criteria for licensing. Often, legislation is passed allowing programs to operate before these programs have developed qualification criteria or licensing standards for Blue Cross to review. This delay between when legislation is passed and the development of necessary information for review of appropriateness and need presents a real dilemma for Blue Cross, particularly in light of the proliferation of various provider groups and service modalities.

Mental Health Benefits. Certain employer groups contracting with Blue Cross have requested a cut back in mental health benefits. In an attempt to implement effective cost-containment programs, employer groups have requested higher co-insurance and higher deductibles on mental health coverage. Their rationale is that the mental health costs to the group are significant; yet such benefits are utilized by a very small percentage of their membership.

Such groups have requested allocation of funds to more popular and utilized coverage, such as well-baby, dental and vision care, and hospice services.

Employer groups have been increasingly more critical of Preferred Provider Organizations (PPOs) with regard to their lack of development of cost-effective programs in the area of mental health and are concerned about signing up with PPOs until they, along with the insurance industries, limit or restrict their mental health coverage.

Growth in the Mental Health Provider Community. In the State of California, there exists a situation of too many health care providers for the population in need of services, too many hospital beds, and too many physicians per patient. All of these situations create a significant problem in terms of utilization. However, distribution of resources does not always correspond to need and thus, there are many areas which are vastly underserved.

Mandated Mental Health Benefits. Mandates can encourage availability of certain mental health services. However, mandates may limit existing service because they are interpreted as maximum rather than minimum levels of care.

In conclusion, during the last twenty years, government has invested heavily in new treatment settings and in training programs to staff them. Cumulative changes in the structure of the mental health system may have pushed existing benefits toward obsolescence. To prevent this from occurring, there must be rationally developed benefit structures and delivery systems. Administrative components must be designed to cost effectively draw on these system changes as well as meet the demands of the diverse populations needing different levels of mental health service intervention.

LESSONS FROM THE PRIVATE SECTOR

Michael F. Kipp

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MR. KIPP PRESENTS THREE LESSONS FROM THE PRIVATE SECTOR RELATED TO UTILIZATION OF CAPITAL MARKETS, USE OF MENTAL HEALTH PROGRAMS AS A JOBS PROGRAMS, AND COSTS OF HOSPITALIZATION. HE ALSO IDENTIFIES SEVEN RULES FOR LEGISLATORS IN DESIGNING AN EFFECTIVE SYSTEM.

Three Lessons from the Private Sector

Lessons from the private sector in financing mental health services are as valuable to legislators as to practitioners and administrators, although for different reasons and from a slightly different perspective. If followed, they are powerful tools from which a legislator can establish the framework for a financially sound and responsive system.

The first lesson calls for a careful distinction between jobs programs and mental health programs. Wherever the mental health system is being used as a jobs program, it is contributing dramatically and unnecessarily to the inflated cost of health care and damaging the capacity of the field to extend or even continue its practice.

Second, capital markets should be used to finance public mental health services to a far greater extent than at present. The current situation is paradoxical. On the public side there is an almost constant cry that there are insufficient funds to do the job. On the private side, never before in history has there been more capital available for health care ventures. Domestic and foreign investors alike still perceive health as a major growth area and an element in our economy accounting for more than 10% of the GNP. Cost-containment pressures are putting a de facto cap on health care expenditures and are forcing a redistribution of health care goods and services within that cap. This redistribution takes the form of some very creative activity in health care management, attracting private capital into ambulatory surgery centers, health maintenance organizations and the like. Therefore, the mental health field, in general, and state policy makers, in particular, need to work harder to attract private capital to the task of doing the public mental health job.

The third lesson has to do with one of the major underlying factors that are fueling the financing problem in the mental health field today. One of the ideological basics is the notion of a continuum of care which includes less costly and restrictive settings such as partial hospitalization, structured outpatient programs and half-way houses. From a statistical perspective, the coninuum is a myth. Although there are many people developing creative alternatives to hospitalization, it is crucial to note that almost eighty cents on the dollar in mental health is spent on hospitalization. From a macro-economic perspective, the structure of the industry consists of hospital beds and private practitioners with very little in between. As Dr. Loren Mosher, (1983) recently identified: "two major recent reviews...have pointed out that every study comparing non-hospital with in-hospital psychiatric treatment has found the former to be as good as or better than the latter." The major costs of mental health care are fueled by excessive hospitalization: legislators must be aware of its perspective in designing ways to effectively finance future mental health services.

Against this backdrop, it is possible to construct a handful of legislative principles which, taken together, constitute a coherent legislative fabric for underpinning a coherent public mental health program.

In the main, despite the fact that mental health is commonly perceived to be a people business, these underpinnings are largely administrative. Administrative matters make a profound difference in how this system comes together. Legislative bodies play a critical role because they set the administrative stage for running an appropriate system. Expressed as legislative principles, these administrative fundamentals can be identified in seven critical areas:

Management and Evaluation: a Necessity. Operating data is fundamental. Any million dollar business uses operating data to evaluate its performance: retail business talks about dollars of sales per square foot of selling space; steel refers to tons of production per day. Yet in public mental health there have been few cross-state comparisons of spending or of effectiveness using solid data. There has been an over-emphasis on the "people" aspect of the business given legislative interest in applying dollars to human needs. If it can't be measured, it won't be managed. Facts are fundamental to effective decision making.

Coordination Among Governmental Entities. From a legislative standpoint, it is essential to push toward integrated management. There needs to be empowered coordination of services within a geographic area. For example, all too often, the community mental health centers are at war with the state hospital people who are in turn warring with county officials; and everyone fights with the Feds. A fundamental prerequisite for a coherent system is to have somebody in charge. Just flowing dollars to target populations tends to make things confusing and incoherent. Yet, it is also futile to try to make consistent all of the funding sources and legislative factors that surround the mental health field. It is important to put in place within each geographic area the capacity to manage a service system. When there is a lack of organization in the system, a legislative body may rush in and respond with categorical programs for special groups, claiming nothing is being done.

Integrated management between state and local services is critical to long-term mental health care. Moreover, the absence of a unified management system radically inflates the cost of services overall.

Capitation and Patterns of Utilization. It is powerful to think about the possibility of capitation in the mental health arena. Drucker's famous statement that 10% of the events account for 90% of the results is important to remember. There are concentrations in any base of data. For example, most employee benefit managers will tell you that 12% of the employees and their dependents consume 70% of the health care benefits. Public systems present the same profiles. Yet in almost every case, a "casualty management" system has developed where predictably heavy service users enter the system, usually in crisis and at the most expensive levels of care. A hybrid "mental health maintenance organization" needs to be built for high use patients. A capitated system allows for the reduction of risk and more effective management of patients who are predictably heavily involved.

Varying Levels of Care Related to Patient Needs. It is important to establish the legitimacy of varying levels of care. As yet, only a few states have built this type of distinction into their state Medicaid plans. The mental health system should be calibrated for patients of different levels of need, for example, hospitalization, skilled nursing facility care, domicillary care, etc. with specific admission and length of stay standards. Classifying buildings, staff and patients allows for a better allocation of resources to patients' actual needs. However, the level of care system needs legislative support to make sure that it exists not only in state health plans but in comparable support plans as well, so that it can effectively differentiate reimbursement, staffing and other standards across the board.

Public/Private Partnership in Service Provision. State administrative codes should allow for flexibility in the selection of vendors, with the ability to contract with the private sector, in ways that are coherent and responsive to what the needs of these sectors are. For example, the Medicaid amendments in 1968 gave the biggest push to the hospital industry. They allowed for the inclusion of debt in the reimbursement system. This provided an opportunity to go into the capital markets and raise capital to build hospitals which would then be paid for by reimbursement mechanisms.

Yet, in most states debt is not allowed as a reimbursable component. Therefore, if state agencies want more capacity (e.g. rehabilitation of buildings, construction of half-way houses) incentives are lacking for attracting private capital. These incentives must be available in order to access financial markets and given even voluntary agencies the capacity to build the kinds of programs the state is interested in seeing. There are profound ideological barriers to contracting with the private sector, preventing meaningful exchanges on how to get things done. However, there are problems in managing a provider system whether that provider system is public, private non-profit, or profit-making.

Interagency Coordination: Mandatory for the Mentally Ill. The necessity for interagency coordination needs to be built into the state policy fabric. There are a variety of ways this can be done, but the problem that frequently arises is that there are interagency battles over various types of patients in the system. Often, the administration of the human service system is determined by court decree of a class action suit. Listing the needs of the mentally ill reveals a whole spectrum of areas well beyond mental health treatment per se. This makes it important that there exists a coordinated mechanism between state agencies so that people get admitted to a system and not an agency. Frequently, if someone is admitted to the mental health system, (which often serves as the default system for all of human services), then corrections, social service or child welfare can sign off on them.

Developing Consensus on the Limits and Priorities of Public Responsibility. Forums at the state level must be established to discuss the boundaries of responsibility for the public mental health system. Are resources to be extended over the broadest possible population base, or concentrated on the sickest and the poorest? Are there limits of reasonableness which should be applied in treating a badly damaged patient with a poor prognosis? These are not easy questions, nor are their answers ever permanent. Some determination must be made, though, of the public's responsibility and priorities. This will influence how aggressively and in what direction policy makers can deal with resource allocating questions. Each administration needs to debate these parameters so that some kind of resolution can be found.

States historically have borne the burden of financing and managing mental health services--often with meager technical assistance. State legislators and administrators are encouraged to find common cause with one another in establishing an appropriate and expanding base of knowledge about these responsibilities and to develop the most coherent legal framework possible for effective operation of this major state enterprise.

ACHIEVING ADEQUATE MENTAL HEALTH COVERAGE

John Krizay

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MR. KRIZAY EMPHASIZED THE NEED FOR ADEQUATE MENTAL HEALTH INSURANCE COVERAGE, ESPECIALLY FOR THE CHRONICALLY MENTALLY ILL. PROPOSALS FOR IMPROVED MENTAL HEALTH COVERAGE INCLUDED PUBLIC RELATIONS AND EDUCATION, MANDATES FOR REASONABLE MENTAL HEALTH COVERAGE AND THE NEED FOR INCREASED PRIVATE SECTOR INVOLVEMENT IN THE DELIVERY OF MENTAL HEALTH SERVICES.

Private Insurance Coverage for Mental Illness

Presently, private sector health insurance does not adequately cover mental illness, particularly for the chronic patient. There are two fundamental issues which must be addressed with regard to the funding of mental illness. First, treatment, even short-term treatment, for mental illness can be very costly to the individual, due to the nature of the treatment -- e.g., frequent, repeated office visits which often extend into years. Second, the length of stay for inpatient hospitalization is quite a bit longer for mental illness than for other illnesses.

Most private health insurance plans have restrictions of some sort limiting mental health coverage. Often, these restrictions include dollar maximums, co-payment requirements, or visit restrictions. Restrictions of this sort often prove to be very costly to the long-term patient who must absorb costs not covered through an insurance plan.

Many mental health professionals are content with the existing minimal levels of insurance coverage for mental illness. Presently, there are incentives to provide care to acute patients who respond quickly to treatment rather than to chronics who often require extensive outpatient treatment or longer lengths of stay, when inpatient treatment is indicated. This is particularly the case with hospitals, as 60% of private plans currently reimburse for inpatient psychiatric care on the same basis as physical illness. Hospital physicians and administrators do not wish that system to change. They are aware of the fact that psychiatric inpatient costs are less than other inpatient costs; however, the per diems are the same. Psychiatric care is less expensive than other medical care which often requires the use of expensive equipment and the use of 24-hour nurse surveillance; however, hospitals are able to be reimbursed for psychiatric patients at a rate which more than covers the actual expenditures.

An even greater factor contributing to the minimal insurance coverage of mental illness is that of public opinion. Unlike other illnesses, public attention is focused on the mental health provider, not the patient. The public image of the mental health professional is rather negative, perhaps due to extensive media exposure of forensic cases. It is in these cases that psychiatrists are often required to substantiate their diagnoses and treatment methodologies; this is not the case for physicians treating other illnesses. This judicial scrutiny of the mental health professional has led to general skepticism by the public of psychiatry as a discipline adhering to a scientific model. This, in turn, has led to skepticism about the benefits of psychiatric intervention with regard to mental illness.

The Truth About Mental Health Coverage

A very common justification of minimal mental health coverage by insurance companies has been that mental health coverage is costly -- this is not true. The truth about mental health coverage is that it is not expensive in an insurance sense.

When comparing the cost of mental health coverage to other kinds of coverage, data indicate that even the most liberal mental health coverage (such as the Federal Employee's Program available to federal employees until 1982) costs half as much as coverage for surgery or for dental care. The administrative costs alone for dental coverage are exorbitant, yet such coverage is growing in popularity. Presently, two-thirds of all private sector health insurance plans include dental coverage -- such coverage has nearly doubled in the last three years. It would be much more reasonable for consumers to insure against mental illness; such coverage is not highly utilized but is potentially very costly to the individual. It would be more reasonable for insurance companies to offer insurance coverage for mental illness, not for dental care. The cost of dental care, while expensive, is evenly spread over the population over a lifetime; it is predictable. Insuring for dental care is akin to insuring one's car tires while ignoring the rest of the vehicle.

The purpose of insurance should be to serve as protection against unpredictable, costly incidents such as fire, theft, and auto collision. Dental and maternity costs, unlike these, are predictable events. However, maternity and dental coverage are very popular. Insurance companies have used the sanctity of the miracle of birth as a ruse to get a very large portion of an insured group to pay for that which a very small percentage of that group will plan for and utilize in any given year.

Proposals for Adequate Mental Health Coverage

Mental health coverage is currently inadequate but could be significantly improved. There are several necessary steps toward improving mental health benefits. The first step involves public relations. Insurance companies are often responsive to client preference; benefit packages often reflect what a given population prefers to pay for. However, the public must be made aware of the potential severity of mental illness and the need to have access to adqeuate insurance coverage for mental health care. The public should have an understanding of the potentially high costs of mental illness, both emotional and economic, on its victims and their families. The fact that mental illness is rarely terminal makes it perhaps more serious than those diseases considered terminal -- its duration and effects are limitless.

The public must also be made aware of the randomness of mental illness -- its victims are not pre-selected. However, the incidence of the disease is predictable in a whole population. The fact that its incidence is random, predictable in a whole population, and costly makes mental illness very insurable, as these are three basic tenets to insurability. This is why there is fire insurance, insurance against theft and auto collision insurance; mental illness should be added to this list. The public needs to be educated about the risks they incur by not insuring against it.

Professional psychiatric associations can aid in the public education efforts by not minimizing the potential severity of mental illness. Psychiatric associations, although with good intent, may have done a disservice to the mentally ill, particularly those who are chronically ill, by underplaying the importance of intervention under the rubric of de-stigmatization.

The second step toward assuring adequate mental health benefits is legislating reasonable mandatory coverage for mental illness, particularly for those who are chronically mentally ill. Mandates for minimal care have been interpreted as maximum levels of coverage and have served as a disincentive for a more comprehensive set of services, especially those needed by the chronically mentally ill. While some current efforts to mandate mental health coverage have been counterproductive, mandated coverage is necessary. In some instances, presently mandated coverage has provided less coverage than what insurance plans would otherwise have provided without the mandate. Because gaining public support for adequate mental health coverage will be a difficult and time-consuming process, mandated coverage is essential; however, it must be reasonable and must not further limit what coverage is already available.

Legislators must also be educated about the actual cost of mental health benefits. They should be made aware of cost savings to their states. There is evidence that where private health insurance coverage of mental illness is good and adequate, there is a shift from public to private sector mental health care. This means that persons with adequate and appropriate private insurance coverage are less likely to access already overloaded public services. This shift can represent a significant cost savings to a state that expends a large portion of its mental health budget on state-operated institutions and state-funded programs.

The third step toward adequate mental health benefits is acknowledging the need for private sector involvement. The general public as well as legislators must think beyond merely buying a service; they must think of developing a service system that will create efficiency and promote progress. These two objectives, i.e. developing an efficient and progressive service system, can best be served by giving the "power of the purse" to the individual who uses the system. This means an emphasis on private sector insurance. Public sector vouchers should be used to fill in the gaps in coverage that private insurance plans do not cover.

Consumer control over the purchase of mental health services has several benefits. Individuals can put the professional market to a test and can find the most appropriate services for their needs. As accountability to the patient increases, more competent professionals will be attracted to the mental health field; the quality of services will be greatly improved.

The general public and mental health professionals must promote, encourage, and authorize the establishment of Preferred Provider Organizations (PPOs). PPOs offer an efficiency that only comes out of private initiative. Such an initiative promotes the bringing together rather than the separation of mental health professionals who, heretofore, have been at war. With a common economic base, they will work with one another toward a common goal: good and adequate mental health care.

Treatment of mental illness and the financing of that treatment is the step-child of medicine. It is a curious phenomenon. For, if measured by diagnostic category, the care and treatment of the mentally ill constitutes the largest, single category, in terms of care, of all health services. Moreover, this is a disease that will cost the community whether it chooses to finance treatment or whether it chooses to deal with the victims in some other way.

From earliest times, mental illness has been viewed as a community burden -- people do not readily accept bizarre behavior which may be displayed by the mentally ill in their midst. The choice always was: treatment or care; compassion or incarceration. Either way, it is a community cost. In this age of science, there is a capability for finding the appropriate treatment; in this age of reason, there should be acknowledgement that this illness belongs, with others, in the health plans of our citizens on a basis equal to all other illnesses.

FINANCING HUMAN SERVICES: THE CHALLENGE

Alfred J. Kahn, D.S.W.

DR. ALFRED J. KAHN IS A PROFESSOR OF SOCIAL POLICY AND SOCIAL PLANNING AT THE COLUMBIA UNIVERSITY SCHOOL OF SOCIAL WORK WHERE HE HAS BEEN A FACULTY MEMBER SINCE 1947. HE IS CO-DIRECTOR OF THE CROSS-NATIONAL STUDIES OF SOCIAL SERVICE SYSTEMS AND FAMILY POLICY AND HAS PUBLISHED OVER 20 BOOKS, AND SOME 160 ARTICLES, AND MONOGRAPHS RELATING TO HUMAN SERVICES ISSUES.

DR. KAHN NOTED THAT THE HUMAN SERVICES REPRESENT A SIGNIFICANT PORTION OF PUBLIC EXPENDITURES. HE ALSO DESCRIBED SEVERAL DEMOGRAPHIC DEVELOPMENTS WHICH WILL AFFECT HUMAN SERVICES POLICY AND STRESSED THE NEED FOR IMPROVING PLANNING AND FINANCING MECHANISMS.

The term "human services" is an American equivalent for the generally used term, "social services". When costs are listed, they appear as "social welfare expenditures". The Office of Human Development Services in the Department of Human Development Services has a narrower jurisdiction, generally known internationally as the "personal social services". Here, in any case, we talk about the broader field and from the perspective of the states.

Although the action is often fragmented, categorical, and crisis-oriented, these services represent a major portion of public sector spending at all levels of government. They should constantly be at the center of political attention and deliberate political choice.

For example, in 1980, 54.4% of the federal budget and 64.1% of state and local government budgets went to human services. If federal grants are excluded, the state/local percentage for 1980 was 52.8%. Of this, 40.5% was spent on education and 8.7% was spent on public aid. The state/local human services expenditure percentage has remained relatively stable in recent years, ranging from 60-64% between 1970 and 1980.

The human service challenge is shaped by demographic and social change.

Thus, we cannot expect to escape the need for child care services. The percentage of families in which both parents work has risen so rapidly during the past 20 years that this family structure is now normative. In 1960, in only 40% of all couples in the U.S. were both members working outside the home. But by 1981, this percentage was 62%. Another trend is that mothers are returning the work earlier, that is, before their children are grown. Approximately 57% of working mothers with a child under the age of 18 are working, as are 50% with a child under 6 years of age, and 45% with a child under age 1.

Nor can states ignore single mothers as a social service target. Approximately 12.2 (M) million children in the U.S. reside in single-parent households, 15.9% of all families are sustained by women and 21% of households with children under the age of 18 are sustained by women. However, this percentage is much higher for certain population sub-groups. An estimated 50% of all black families are headed by single parents. In addition, 1 in 7 white children and 1 in 4 black children in 1979 were born to teenaged mothers; and the rate for white teenagers is increasing.

The policy implications of these figures are evident in the relationship between poverty and single-parent families. Single-parent families constituted 50% of all poor families in the U.S. during 1982, and 53% of poor families with children. Furthermore, while the overall national poverty rate was 15% in 1982, it was 40.6% for female-headed households.

Some important policy issues are also emerging in the area of long-term care for the elderly. Currently, 11% of the U.S. population is over 65 years old; but by the year 2000, this percentage is expected to be 13%, and is expected to jump to between 18-22% by 2030. Only about 20% of the elderly (over 65) population remains in the labor force, and life expectancy is growing. However, persons in their late 70's and older tend to experience some loss of functioning capacity. Only 1 in 10 of those 65-74 years old require assistance to perform daily living activities and only 16% of 75-84 year olds do. However, this figure is as high as 4 in 10 for persons over 85 years of age. Approximately 5-6% of the 65+ age group receives institutional care; but evidence indicates that for every person in an institution, there are twice as many people with the same physical conditions who remain at home.

These demogrpahic trends raise a number of questions regarding public sector responsibilities for human services provision. While there is a case to be made for an updated and renewed federalism, the states have the right to insist as well on a stable federalism. They have a right to expect the federal government to fulfill its proper role; and they also require certain kinds of assistance activities from the federal government. This is particularly true since some problems are by their nature national. Moreover, the federal government has access to tax dollars that states do not. Some problems require coordination between states that can best be handled at the national level. Other issues which state governments will encounter involve actions that are mutually interwoven and therefore require national policy and cooperation.

On the other hand, with the federal government in the lead on Social Security, SSI, Medicare, Medicaid, AFDC, and Food Stamps, as well as in the pension and tax areas, the states have obvious advantages in planning and delivering services. Here we refer particularly to: long-term care for the elderly, child care, services to the handicapped, programs responding to teenage pregnancy, mental health services, and innovative efforts to help people out of poverty.

Each of these has specific characteristics which cannot be summarized here. However, there are many creative possibilities for two and three tier governmental interrelationships and new forms of privatization as well.

Some options for addressing specific policy issues include the employment of graduated fee schedules, use of tax credits, and redefining federal-state roles. For example, currently 70% of all 3-5 year old children are in some kind of group care for some part of the day. It may be cost effective to develop pre-kindergartens and after-school programs as part of the public educational system. The federal government could provide matching funds to local school districts to encourage the development of such programs. In the area of long-term care, state development of an integrated social service system which includes long-term care could be encouraged by federal tax credits related to the elderly. In all areas of social service, graduated fee schedules would bring all socio-economic groups into the same service system and help ensure the provision of quality care.

In order to continue to address the issue of improving human service financing, the states must have an adequate planning capacity, and government taxing power must be used effectively. State governments must retain citizen contributions to the planning process and recognize the importance of monitoring both state human service programs and federal responsibilities in this area. In addition, efficient use of the taxing base and the general economic health of the country are crucial to efforts addressing human service needs.

REORGANIZATION, CONSOLIDATION AND CUT BACK MANAGEMENT

Thomas N. Gilmore

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MR. GILMORE DISCUSSED THE NEED TO RESTRUCTURE PLANNING METHODS TO MEET THE CHALLENGES OF DECREASING RESOURCES. HE ALSO OUTLINED SOME OF THE BARRIERS TO EFFECTIVE PLANNING IN THE PUBLIC SECTOR.

Planning technology was developed during an era of ever-increasing resources. Modifications in the process are necessary to adequately address planning needs during periods of economic decline. Retrenchment causes substantive challenges as well as process ones. During periods of economic growth, planning activities are supported by the extra margin of profit, which is absent during periods of fiscal retrenchment (Gilmore and Hirschhorn, 1984).

Planning in Periods of Growth and Restraint

There are several differences between "growth" planning and "reduction" planning. Many of the assumptions upon which growth planning is based do not necessarily hold true for retrenchment. For example, during periods of increasing resources, the future is viewed as predictable, goals are considered fixed and the central resource problem is efficient allocation. However, during cut backs, the future is no longer predictable, and goals are questioned. In addition, the central resource problem often becomes one of generation, simply to maintain current levels of activity.

Another factor emphasizing the difference between growth and reduction planning is the time factor. Particularly in the corporate structure, much more time is usually spent on growth planning; yet under cut back conditions, managers may be given only a few weeks to reduce their budgets and terminate employees. These factors also produce different psychological effects on employees. During growth periods, there are often strong incentives for employee innovation in the development of new projects. In contrast, periods of cut backs create anxiety and uncertainty which decreases willingness to undertake new projects. Reduction planning often increases the importance of inter-agency cooperation, and requires certain changes in implementation strategies since resources may not be available to help minimize conflict (Hirschhorn and Associates, 1983).

Public Sector Reduction Planning

The public sector presents some special difficulties for the process of reduction planning and cut back management. One problem lies in the traditional relationship between the legislature and executive agencies. These "players" have become accustomed to the rules of a particular kind of "game", and find it difficult to adapt to changing circumstances. For example, executive agency directors often request budget appropriations in excess of their real needs. This allows for a margin of cut back by the legislature that will not decrease their operations. However, in periods of fiscal crisis, legislators need real information about which programs are crucial. In order to overcome this problem, it will be necessary to build a trusting relationship between the participants in the budgetary process.

There is also a need to create an environment where creative policy dialogue can occur. The high rate of public sector employee turnover due to the political process hinders the establishment of personal and professional relationships necessary for developing such an environment. In addition, many public sector managers feel that political considerations prohibit them from choosing innovative courses of action.

However, there are some examples of innovative programs which attempt to change incentives. The new Medicare payment structure diagnostic related grouping (DRG's), represents a public sector attempt to contain costs by changing the incentive structure.

Model policy-making processes, which take the changing resource availability into account, are being developed. The State of Connecticut has developed a budget priority negotiating process which includes representatives from State and local government and private agencies. This group negotiates a set of state human services spending priorities which is sent to the appropriate legislative committees. Public input is guaranteed by the election of community representatives and through open meetings. Preliminary reports indicate this effort has been successful. However, this process may not necessarily be appropriate for all states. The issue of whether allocation decisions are the duty of the legislature, as an elected body, or whether such decisions should be made by some sort of professional council is debatable. The Connecticut model of negotiations has removed some of the lobbying pressure from legislators, and legislatures often favor policy processes which calm vocal constituents.

There are several substantive challenges for cut back management in the public sector. One problem involves the use of an "across the board" cost

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reduction strategy. This kind of approach to budget reduction is sometimes politically less difficult to make than targeted cuts. However, across the board cuts penalize the efficient and reward the inefficient. A more "anatomical" approach to reduction would eliminate inefficient program components and cut waste, but leave successful programs intact. This would help provide incentives for effective public management. Certain psychological trauma for employees is also associated with across the board cuts. Employees tend to feel that their efforts are not worthwhile, and that they are powerless and vulnerable. Budgetary cuts that are made according to a clear set of priorities produce less anxiety, because personnel feel they can survive by redirecting their efforts along the priority lines.

It is also difficult to define policy priorities in the public sector. Legislatures, and executive agencies to lesser extent, are "reactive" rather than "pro-active" organizations. That is, public agencies often pay attention to an issue only after it has reached a crisis stage. Therefore, many of the planning activities in the public sector are undertaken in a crisis mode rather than a preventive one. Because of this lag, special planning units in government tend to focus on past issues rather than fledgling ones.

Many planning activities are "habit driven." Numerous state plans and other documents are produced, but rarely used. An audit of all mandated planning activities on a routine basis would eliminate such underutilization of planning resources.

The formation of special commissions or task forces to address specific policy issues can also present barriers to efficient planning activities. These groups often have a life-cycle which follows a definite pattern. Initially, there is strong interest in the issue, and leadership is available. However, if group priorities and an action plan are not developed quickly, key members begin to lose interest and send representatives instead of attending themselves. It is also necessary to assign individuals responsibility for certain specific projects in order to insure continued commitment. These groups often continue to exist after their original purpose has been fulfilled because it is difficult to dismantle an organization. Therefore, there are sometimes several groups with comparable goals or issue focuses which have been formed during different times and with different membership. This redundancy can create confusion and hinder effective action (Gilmore, 1983a).

Alternative Models for Planning

In the public sector, there has been a succession of different types of planning - master planning, comprehensive planning, strategic planning, and contingency planning. The shifts signify attempts to cope with the greater uncertainty. Comprehensive and master planning suggest a degree of control over the system and its environment that no longer exists. What appears as a 'milestone' in a comprehensive plan, can too often become a "mill stone" that prevents the system from flexibly responding to a new reality, constraint, or opportunity. Below are outlined three alternative models that acknowledge the new condition under which planning now takes place.

The first is called "idealized redesign." This method has been extensively developed by Russell Ackoff (1981) to allow all parties with a vested interest in a particular issue to participate in redesigning the system. It is similar to zero-based budgeting because the group begins with the assumption that the system no longer exists and must be redesigned in an ideal sense. This design is subject to only two constraints: the system must be technologically feasible and operationally viable; if brought into being it could function and sustain itself. Political "realities" are not considered at this point. Once the group has achieved consensus on the idealized redesign, they then must ask what are the minimum compromises that must be made to make the design feasible. The advantages of this process are that it encourages creative thinking and innovation. Rather than solving problems, people often dissolve the problem. The excitement associated with the ideal often unleashes feelings of commitment and energy that overcome what may have been thought, at first, to be insurmountable obstacles. Most of all, it clarifies the core values which provide guidance in times of great uncertainty and change.

The second method is called "portfolio planning." A group develops a list of possible actions, new programs, or proposals so that each one has been considered and meets some broad criteria of desireability. The number of items is far greater than could ever be implemented simultaneously. The group then waits for the opportune moment to move to the next stage of implementation of the idea. This model powerfully acknowledges the fluidity of the environment within which one must plan and capitalizes on these ongoing changes by being ready to act when events create the right climate. It combines a proactive orientation of identifying desireable projects, and a reactive orientation of responding to external events to implement the ideas.

The third model of planning is called "search conferences" (Gilmore, 1983b). Search conferences are like planning retreats of the major stockholders in a problem area. Participants begin not by looking at the problem, but at the widest environment possible - overall futures for the country. The group develops and discusses the overall value directions first and then begins to focus on the issue that has brought them together. The effect of this outside to inside direction is to bring new ideas to bear on the problem and to relink the issue area with events in other sectors of society. Like idealized design, it greatly increases creativity and commitment.

LONG-TERM CARE: ALTERNATIVE FOR THE FUTURE

Stanley S. Wallack

STANLEY S. WALLACK, PH.D., HAS BEEN DIRECTOR OF BOTH THE UNIVERSITY HEALTH POLICY CONSORTIUM AND THE HEALTH POLICY CENTER AT BRANDEIS UNIVERSITY IN WALTHAM, MASSACHUSETTS SINCE 1978. HE WAS FORMERLY AFFILIATED WITH THE OFFICE OF THE ASSISTANT SECRETARY FOR PLANNING AND EVALUATION OF THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES (AS DIRECTOR OF THE DIVISION OF HEALTH RESOURCES)[AND THE CONGRESSIONAL BUDGET OFFICE (AS DEPUTY ASSISTANT DIRECTOR FOR HEALTH, INCOME ASSISTANCE, AND VETERANS' AFFAIRS). IN HIS CAPACITY WITH THE CONGRESSIONAL BUDGET OFFICE, HE WORKED WITH SENATE AND HOUSE LEGISLATIVE COMMITTEES ON A VARIETY OF HEALTH CARE ISSUES. DR. WALLACK'S RECENT RESEARCH ACTIVITIES HAVE CONCERNED PRIVATE FINANCING OF LONG-TERM CARE, PERFORMANCE OF PREPAID DELIVERY SYSTEMS, AND DEVELOPMENT OF COST EFFECTIVE PAYMENT AND DELIVERY SYSTEMS.

DR. WALLACK EMPHASIZED THE NEED FOR DEVELOPING ALTERNATIVES TO LONG-TERM CARE, CITING THE HIGH COSTS OF CURRENTLY AVAILABLE CARE AND THE PROJECTED GROWTH IN THE POPULATION NEEDING SUCH CARE AS RATIONALES FOR THIS DEVELOPMENT. HE DISCUSSED THE COST-EFFECTIVENESS OF SEVERAL SERVICE DELIVERY OPTIONS NOW BEING UTILIZED TO ADDRESS THE LONG-TERM CARE NEEDS OF THE POPULATION.

Deinstitutionalization of the mentally ill and mentally retarded and the burden of increasing costs of nursing home care for the elderly have created service delivery and fiscal problems for state governments. The aging population of the United States is expected to grow, and the projected costs to states are particularly problematic. Of the approximately $13.5 Billion (B) in government expenditures for long-term care for the elderly in FY 1980, 10.5 B or 79% was for nursing home care. Public long-term care expenditures are directly tied to welfare programs, with Medicaid being the major public payer. Because there is virtually no private insurance coverage for long-term care, the financial pressures on the Medicaid program will become more intense as the number of individuals needing long-term care increases.

Costs of Long-Term Care: Medicaid, Nursing Homes and Home Health

The cost of long-term care is becoming an increasing financial burden for the elderly. In fact, almost half of the elderly in nursing homes who are supported by Medicaid were not poor initially; rather they were forced to expend all their financial assets to meet the high costs of institutional care. Regardless of higher real incomes of the elderly in the future, the number of elderly forced to rely on Medicaid funding for long-term care will expand as long as catastrophic nursing home costs continue to be met by "out-of-pocket" payments. Increased reliance on Medicaid funding to meet the costs of long-term care coupled with sizable reductions in state Medicaid budgets requires the development of a system of financing and reimbursement which will encourage appropriate utilization of alternatives to high cost institutions.

One possible alternative for reducing the cost of nursing home care is to provide for an expansion of home health care services provided to the elderly. The results of several studies suggest, however, that expanded home health care services will not necessarily reduce nursing home utilization or overall health care costs. There are two major reasons why this is true. The majority of chronically ill elderly still live in the community; therefore, expansion of home health services may simply serve a new population rather than reducing the nursing home population. In addition, some areas of the country presently have a significant unmet need for nursing home beds, and persons waiting in hospitals will fill any beds vacated by elderly individuals receiving home health care services.

Moreover, there are inadequate incentives built into the proposed home health care system. Thus, even if the nursing home population is reduced, the increase in persons receiving home health services might result in a greater total number of individuals receiving health care services.

However, even though the fiscal argument is subject to question, a moral argument for development of non-institutional alternative remains: preliminary data suggests that patient outcomes are better for elderly receiving home care services than for those receiving institutional care.

Development of Long-Term Care Alternatives

State governments will have to assume primary responsibility for developing workable solutions to the problem of long-term care, solutions for which there are adequate resources. Affected families and more politically powerful provider organizations will pressure state governments to accept such responsibility.

Several factors are essential to the development of successful and cost-efficient alternatives to nursing home care. The solution probably should incorporate capitation payments to providers to encourage efficient service utilization patterns and to limit total expenses. A broad range of services must be available so as to maximize substitution for high cost services and, thus, control costs. Public funds must be pooled and streamlined to discourage cost shifting and inefficient utilization patterns. Finally, insurance or risk-sharing elements must be included to develop a revenue pool.

Currently no system includes all of the above elements, but some do approximate this ideal. The On Lok Senior Health Services Program in San Francisco, California, offers a comprehensive capitated program for the very frail elderly. However, because the program is limited to the very frail and disabled, no risk pooling is possible and the private premium is over $700 per month.

Another system approximating this ideal is the life care community, which provides a residential setting for a group of elderly persons. An average life care community contains 300-400 people and has a nursing home bed capacity for approximately 20% of its residents. These organizations are expanding throughout the country, with greater demand for church-sponsored communities than for those sponsored by for-profit agencies.

Life care communities do not pool Medicare and Medicaid dollars. In fact, they largely function outside existing public financing programs. They are privately financed with residents paying an initial entrance fee (on average about $40,000) and monthly fees which cover all housing and medical care costs -- except acute, inpatient care costs. In some communities, individuals pay the same monthly rate whether they reside in an apartment or the nursing facility. Because of this pooling of the costs, there are communities which have 20% of their residents in nursing homes, but have never had a resident go on Medicaid.

This alternative then, represents a self insurance model. These continuing care retirement communities prove that insurance risk sharing can work. But since these communities have substantial entrance fees and require individuals to reside on the campus, they are unlikely to serve a high proportion of our elderly.

The Social HMO: A New Approach

One solution that may be more attractive to a larger number of the elderly is the Social Health Maintenance Organization (Social/HMO). This approach operates within the basic structure of the public financing programs of Medicare and Medicaid, and, at the same time, attacks the basic problems of long-term care service delivery.

The Social HMO, a concept developed at Brandeis University, is a managed system of health and long-term care services geared toward an elderly client population. Under this plan, a single health care provider will enroll a representative mix of people -- from well to significantly impaired -- on a voluntary basis through marketing efforts of the provider entity. The provider assumes responsibility for provision of a full range of acute inpatient, ambulatory, rehabilitative, nursing home care, home health, and personal care services under a fixed budget which is prospectively determined. The Social/HMO is financed through monthly premiums paid by Medicare and by individual enrollees; thus enrollees, providers and public third party insurers share the risks.

The Social/HMO consolidates the system of care at all levels: provider, population, finance, and risk. Such consolidation allows the Social/HMO the potential to be an extremely powerful intervention. Consolidation of services makes it possible to redefine and coordinate provider roles and relationships, and decreases the need for some of the regulatory and reimbursement constraints that currently shape relationships. It also gives providers authority to manage care of individuals across the full spectrum of services. The balanced membership has an extremely important financial function because it creates an insurance mechanism for long-term care through the premium. Prepayment and pooling remove financial barriers to innovation. Giving financial risk to the Social/HMO entity makes cost-effectiveness an important criterion for decision making.

The Social/HMO offers solutions to the major systemic problems. However, because of the limited size of the risk pool and the specter of adverse selection, the long-term care benefit for non-Medicaid enrollees will be limited initially. It will not fully address the problem of financial protection. Nevertheless, the protection that the Social/HMO offers is substantial. At one site, the chronic care benefit is expected to increase to $1,000 per month; in no case will it be less than $6,000 per year.

The Social/HMO is being tested by four provider groups: SCAN Health Plan (Long Beach, California), Ebenezer Society/Group Health Plan (Minneapolis, Minnesota), Elderplan (Brooklyn, New York), and the Kaiser Health Plan (Portland, Oregon). It is anticipated that three of the sites will begin marketing in the summer of 1984. The Social/HMO should provide all levels of government, providers, and potential private insurers with valuable information regarding the feasibility of integrated systems of care for the elderly that are based on insurance principles.

Public Policy and Planning for Long-Term Care

The current status of financing for long-term care is reminiscent of that of acute care financing 40 years ago. Inadequate financial protection exists, but it is not clear whether the void will be filled by public or private financing. The current fiscal problems of the federal and state governments are significant, making it very unlikely that adequate public financing will be forthcoming for today's adult population. Recognition of this situation by public officials would enable them to establish policies that encourage private financing and efficient utilization of scarce public dollars in the delivery of long-term care. Taking no action has significant consequences. First, it maintains a state of uncertainty among the private sector actors who might have developed innovative solutions given the correct "signals". Also, it increases the likelihood that inappropriate and stop-gap measures will be forced upon the public sector. Public sector actions, such as mandatory private long-term care insurance or establishment of strong financial incentives to pre-fund such liabilities, would provide the signal that the private sector is to assume the bulk of financial responsibility.

Public policymakers are beginning to develop proposals that better define the roles and relationship between the federal and state governments. Currently under consideration by the Senate Finance Committee, Senate Bill S.1614, the Health Care Coordination Act of 1983, would provide states with the ability to pool Medicare and Medicaid dollars for the purpose of providing comprehensive services to persons eligible for both programs. Legislation such as this would encourage efficient delivery of care and remove the incentive to shift costs between the two programs. However, it does not address the questions of how to finance long-term care for those ineligible for welfare, or how to eliminate catastrophic expenditures.

If these questions are to be addressed through a private financing arrangement that spreads risks, then revenues must be accumulated before the onset of long-term care needs. Pre-funding requires both that the the health care organization assume liability and those joining have knowledge about the future availability of public financing. In projecting their financial liabilities for long-term care services, private insuring organizations need to know what payments they can expect from public programs. Insurers who assume no future public payments will find themselves at a financial disadvantage if they assume liability for services which eventually become publicly supported and are taken advantage of by other insurers. Also, individuals expecting public payment to be forthcoming are unlikely to pay into a private long-term care insurance fund.

If we could remove the uncertainties about the future financing roles of government in long-term care and educate individuals accordingly, the likelihood of appropriate and adequate private sector financing would be enhanced. Short of this, it is hard to imagine a rapid and expansive growth in the area by health insurers. What seems more likely is that long-term care providers, wanting to assure adequate and continuous financing, may develop innovative programs. It is not surprising that continuing care or life care communities are the only entities that have developed viable risk spreading arrangements for long-term care to date. If adequate financing programs were to emanate from providers, it would not be dissimilar to the patterns of innovation which occurred in acute care in the 1930's, when hospitals seeking financial stability established insurance programs.

Recognizing this potential and possibility, it would be appropriate for public officials and long-term care providers to join together to develop appropriate incentives and safeguards for individuals joining such enterprises. Even without such a cooperative effort, it is the private sector's responsibility to develop the delivery and financing systems that will gain the support of public policymakers. In seeking a solution for the inadequate financing of long-term care, it is in the interest of public policy officials at both state and federal levels, to support and foster such endeavors. They must also stimulate the development of efficient delivery systems through legislation or demonstrations.

STATE AND LOCAL PERSPECTIVES ON FINANCING HUMAN SERVICES

Views from a State Executive

Michael Petit

MICHAEL PETIT HAS BEEN COMMISSIONER OF HUMAN SERVICES FOR THE STATE OF MAINE SINCE HIS APPOINTMENT IN 1979, AND MADE HIS PRESENTATION IN THE PLACE OF GOVERNOR BRENNAN. HE HAS BEEN ACTIVE IN THE AREA OF CHILD WELFARE SERVICES, PREPARING A REPORT FOR THE NATIONAL GOVERNOR'S ASSOCIATION ENTITLED ''AMERICA'S CHILDREN: POWERLESS AND IN NEED OF POWERFUL FRIENDS,'' AND HAS RECENTLY CONDUCTED A STUDY CONCERNING CHILDREN'S DEATHS IN MAINE. PRIOR TO HIS PRESENT APPOINTMENT, MR. PETIT WAS THE DIRECTOR OF THE UNITED WAY FOR THE GREATER PORTLAND AREA.

IN HIS SPEECH, MR. PETIT DESCRIBED THE ROLE OF THE EXECUTIVE BRANCH WITH REGARD TO HUMAN SERVICES FINANCING. HE SPOKE FROM THE PERSPECTIVE OF A REPRESENTATIVE FROM A SMALL, BASICALLY RURAL STATE AND DESCRIBED SEVERAL RECENT ACTIVITIES IN MAINE WHICH AFFECT HUMAN SERVICE FINANCING IN THAT STATE.

Presently, states are confronted with growing social problems and the necessity to deal with these problems within a limited resource base. The State of Maine has made a strong effort to address human services issues and has accomplished important advances in recent years.

The Legislature, in response to requests made by the Governor, has responded positively to cuts made in federal support of human services programs. The state has essentially been replacing reduced federal funds with state funds. Consequently, there have been cuts in Medicaid, in the programs supported by block grants and the cuts in the Aid to Families with Dependent Children (AFDC) program have been only those required by federal law over which the state had no discretion. Additionally, broad-based support has been forthcoming from the legislature for many new health and human services including programs for the mentally retarded, the physically disabled, the elderly and children.

Maine has recognized that aggressive responses to management issue that plague many human services can both help increase public and legislative confidence in human service program administration and insure that federal payment mechanisms are used efficiently. In Maine, a concerted effort to address fraud and poor management process has resulted in administrative costs that are only about 3% of total expenditures. The Medicaid error rate has been reduced from 15% to 3% in the past three years, and AFDC fraud has been reduced to less than 1%.

Child support payment collection has been aggressively pursued, and has been used to increase funding available for AFDC since collections have tripled. The number of children who are wards of the state has been reduced through intensive family reunification programs. Maine has also taken the position that generally direct services should be purchased under contract, especially with the non-profit sector, rather than be provided directly by state government itself. This practice helps control the size of the staff and related costs in state agencies. Developing this community-based support has assisted the Department of Human Services with its budget requests to the legislature. In addition, the Maine administration has received strong legislative support for attacking the problem of health care cost containment by implementing prospective payment schemes for nursing homes and attempting to initiate development of such a mechanism for hospitals. They have also held physicians fees under Medicaid constant for the past five years.

The Governor is crucial to any efforts to improve human services in a state. The Chief Executive of the State has the power to set the policy agenda for the state legislature. He is also the only individual with a statewide constituency and who can command more press attention than anyone else in the state.

A responsive legislature is also essential. In the State of Maine, such responsiveness to human services issues is enhanced by two factors. First, Maine has one of the five or six lowest per capital incomes in the nation. People of Maine have the attitude that it is important to maximize utilization of the limited resources. After many years of deprivation, they understand well the importance of helping those in need. Thus, the climate within the state is relatively receptive to human services. Second, there is a relatively high number of women in the legislature. Twenty-three percent of the legislature in Maine is female, a percentage well above the national average of 6-7%. Moreover, Maine's critical legislative committees concerned with human services issues including appropriations, education, and health and institutional services are all chaired by women.

Good working relations between branches of government an enhancement of public awareness are necessary to effectively address human services financing issues. The Executive Branch can initiate these positive relationships in a number of ways. First, extensive interaction with the media through press conferences, individual meetings with reporters and visits to editorial writers increases visibility of human services issues. Also, holding public forums and encouraging legislators to visit state facilities increases the public and legislators' awareness levels. Third, a point should be made to respond very promptly to constituency work legislators need to have done. And finally,the Executive Branch can aid legislators through preparation of quality background materials on issues that may arise.

Early intervention and prevention programs are necessary to the ultimate reduction of costs. The Executive Branch has a basic responsibility to educate others on the need for prevention programs. These programs are less expensive, more effective, and less intrusive in citizens' lives. For example, while it costs only about $500 to provide complete pre-natal care for a pregnant woman, it costs between $20,000 to $40,000 to provide intensive neonatal care to a single premature infant. It also costs only about $50 per year to provide a teenager with conception control, but it costs $5,000 in AFDC payments for only the first year of a baby's life. These maternal and child health services are crucial to insure healthy mothers and babies, the building blocks for future progress in the lives of citizens.

Finally, the fact that the federal government consumes $0.70 out of every tax dollar can not be ignored. The states may cut and slice their budgets; but it is essential to receive these federal dollars to deal with human services problems. At this time, our nation is proposing to build 100 B-1 bombers at a cost of $250 million each, while a total of $398 million is being spent in the federal block grant for maternal and child health services. Heavy investments in military spending need to be balanced with our investments in children.

The way we spend out money may be the most sincere expression of our personal and collective values. States must strive to receive the necessary funding to deal with the problems of the disabled, elderly, and children.

STATE AND LOCAL PERSPECTIVES ON FINANCING HUMAN SERVICES

Views from County Government

Forrest E. Campbell

FORREST E. CAMPBELL IS CHAIRMAN OF THE BOARD OF COUNTY COMMISSIONERS OF GUILFORD COUNTY, NORTH CAROLINA, A POSITION HE HAS HELD SINCE 1977. HE IS IMMEDIATE PAST PRESIDENT OF THE NORTH CAROLINA ASSOCIATION OF COUNTY COMMISSIONERS AND PRESENTLY CHAIRS THE HUMAN SERVICES STEERING COMMITTEE OF THE NATIONAL ASSOCIATION OF COUNTIES. MR. CAMPBELL RESIDES IN GREENSBORO, WHERE HE ALSO PRACTICES LAW.

OVER THE YEARS HE HAS DEVOTED MUCH OF HIS TIME TO WORKING WITH GROUPS CONCERNED WITH THE DELIVERY OF SOCIAL SERVICES AND HAS BEEN ACTIVE IN LOCAL POLITICS. MR. CAMPBELL ADDRESSED SEVERAL ISSUES RELATED TO THE LOCAL PERSPECTIVE OF THE FINANCING AND DELIVERY OF HUMAN SERVICES. NOTING THE IMPORTANCE FOR COOPERATION BETWEEN THE STATE AND LOCAL LEVELS OF GOVERNMENT, HE DISCUSSED SEVERAL STRATEGIES FOR ENHANCING SUCH COOPERATION.

Cooperative planning between all branches and levels of government increases efficiency of both financing and delivery of human services. From a county perspective, one, at times, feels caught in the middle between state and local levels of government, the judiciary system, and the people needing services. Cooperation is especially important at the present time, when human services are not a comparatively high priority.

In North Carolina, there is a state structure for human services programs, which the county administers. The state has financing control and, therefore, also makes major policy decisions. The county administers programs according to the instructions of the state and at the level of funding directed by the state. Obviously, tension may arise between the state and county concerning the issues of appropriate funding for expected services and control over the decision-making process. Taking an inventory of the numerous agencies in each county that deliver human services would both enlighten and educate most county government authorities. Communities are performing hundreds of human services functions quietly and with relatively low funding levels.

In North Carolina, a number of developments have occurred to foster cooperative planning between the various branches and levels of government. First, in conjunction with the Association of County Commissioners' support, a fiscal impact bill was passed, which requires any proposed anticipated costs be projected for legislation affecting local government.

Second, another bill has been passed and will be in effect in 1985 which requires that inflationary costs for future years be estimated and projected. These measures encourage coordinative planning in the human services financing system and aid in controlling costs.

North Carolina has set up the Local Government Advocacy Council, which meets regularly to discuss issues that have an impact on local governments and the delivery of services. The Council membership includes The Executive Committee of County Commissions Association, the League of Municipalities, four legislative members (two Senators and two Representatives), and three members appointed at large. Any appropriate Council recommendations are sent to the Governor or the legislature.

Also, the Council is now researching the changes that have taken place over the last 50 years in the funding mechanisms of many of the state's programs. This study should provide incoming legislators with an historical perspective of the evaluation of various funding mechanisms. Increased coordination and cooperation between state and county governmental bodies will increase efficiency in the delivery of human services.

There are many programs of intergovernmental planning and coordination in various counties. However, ultimately the state must initiate and be responsible for their actions. State efforts can be made easier if officials are experienced at local levels of government before assuming positions of authority at the state level. This local level perspective is important to the development of any state administrative edict. For example, Dr. Sarah Morrow, Secretary of the Department of Human Resources, North Carolina, utilizes her background in local government to aid in administering all of the human service programs in the State. Dr. Morrow has encouraged cooperative action and planning by appointing a small committee of county managers to meet with her and represent the local perspective before administrative edicts are finalized.

The federal courts may intervene if a problem is left unresolved or is unsuccessfully addressed by the federal, state, or county legislative and executive systems. For example, the issue of how to handle and treat an emotionally disturbed child has been addressed in North Carolina by the famous Willie M. case The court's solution to this case alone is costing the State of North Carolina millions of dollars. From a local perspective, successful cooperative planning efforts would be valuable in reducing the risks of federal court intervention and thus, increased costs.

Counties and states can benefit greatly from mutual cooperation. Coordinative planning between levels of government increases efficiency in the delivery and financing of human services. Projection of program costs aids in the selection of human services priorities. Fostering additional communication with the judiciary branch may reduce the risk of federal court intervention. Successful intergovernmental cooperation will lead to responsible and appropriate care that can provide rich rewards to the clients of the human services delivery systems.

STATE AND LOCAL PERSPECTIVES ON FINANCING HUMAN SERVICES

Views from the Judiciary

William Jones

WILLIAM JONES WAS FIRST ELECTED TO THE DISTRICT COURT IN 1976. HE HAS SERVED IN THE DOMESTIC RELATIONS AND JUVENILE COURTS ALMOST EXCLUSIVELY SINCE 1979. SINCE JANUARY 1983, HE HAS BEEN ASSIGNED PRIMARILY TO JUVENILE COURT. HE IS AN ACTIVE MEMBER OF THE NATIONAL COUNCIL OF JUVENILE AND FAMILY COURT JUDGES, CHAIRMAN OF THE COMMITTEE TO COOPERATE WITH THE NATIONAL CONFERENCE OF STATE LEGISLATURES (NCS) AND A MEMBER OF THE CHILD SUPPORT ENFORCEMENT ADVISORY COMMITTEE. JUDGE JONES IS ALSO PRESIDENT OF ADVOCATES FOR CHILDREN IN COURT AND CHAIRMAN OF THE NORTH CAROLINA GUARDIAN AD LITEM ADVISORY COMMITTEE.

JUDGE JONES EMPHASIZED THE NEED FOR MUTUAL UNDERSTANDING AND COOPERATION BETWEEN THE JUDICIAL AND LEGISLATIVE BRANCHES OF GOVERNMENT IN ADDRESSING HUMAN SERVICES ISSUES. HE HIGHLIGHTED SEVERAL STRATEGIES FOR FOSTERING THIS TYPE OF COLLABORATION AND DESCRIBED SEVERAL SUCCESSFUL JOINTLY DEVELOPED HUMAN SERVICES INITIATIVES.

Human services delivery and financing issues need to be addressed by all branches of government in a spirit of cooperation and mutual support. Often, Judges are perceived as being needlessly at odds with other governmental agencies. The National Council of Juvenile and Family Court Judges, the oldest and largest organization of judges in the U.S. with approximately 2,500 members, would like to change this perception of the judiciary. Through training programs, conferences, and presentations, the Council is striving to enhance the quality of judging in juvenile and family court matters.

Difficult human services problems could be more effectively addressed with increased cooperation between judges and legislators. Both the National Conference of State Legislatures and the National Council of Juvenile and Family Court Judges have formed committees to enhance cooperation and communication between judges and legislators. This alliance should provide valuable insight into the problems faced by both groups.

From a judicial standpoint, two sets of concerns have emerged regarding legislative actions. First, bills are often passed which impose new responsibility on the judiciary, without considering the need for accompanying administrative changes. Second, bills may be passed without necessary funding to the judiciary to implement new responsibilities. Increased communication between legislators and judges could alleviate those concerns.

Judges want to do more than simply react to legislative actions. They could contribute at earlier stages in the process through national judicial organizations, state judicial organizations, and individual efforts. Their substantial experience and knowledge of children and family problems could be utilized to aid legislators struggling with similar issues. Ideally, judges and legislators should strive to be partners in solving the problems of children and families.

Collaboration between legislators and judges in North Carolina led to some significant and positive results for children and their families at the last session of the General Assembly. One county now has a child custody and mediation project funded by the legislature as a pilot project. A state-wide guardian ad litem program for abused and neglected children guarantees legal representation and volunteer advocacy for those children. Also, construction will begin soon on a residential treatment facility for emotionally disturbed children.

There are two human services areas in particular that could benefit from joint efforts by all three branches of government at the local, state, and national levels. The first is child support. The Federal Office of Child Support Enforcement (OCSE) provides money to the various groups involved in the child support process and actively promotes collaboration, communication, and cooperation among these groups (National Conference of State Legislatures, the National Council of Juvenile and Family Court Judges, National Governors' Association, ABA Legal Resource Center for Child Advocacy and Protection, and the National Institute of Child Support Enforcement). One of the best examples of interdisciplinary and intergovernmental cooperation between child support groups comes from the State of Illinois. In March of 1983, judges, legislators, people from the Executive Branch, and representatives from NCSL and OCSE met to develop a state legislative agenda on child support. That meeting resulted in new legislation and improved methods of establishing and enforcing child support legislation.

Secondly, the problems of prolonged foster care or foster care drift addressed by permanency planning for children cannot be solved by any single individual, agency, or branch of government. These issues require the commitment of all involved parties to reach any satisfactory solutions. To encourage such cooperation, the National Council of Juvenile and Family Court Judges and the NCSL are co-sponsoring a Permanency Planning Conference in Missouri for trial judges, appellate judges, and legislators. The Council has received large grants from Health and Human Services and the Office of Juvenile Justice and Delinquency Prevention to disseminate this Missouri Conference model of collaboration to all states. A national launching conference will be conducted for this purpose in June. Among those invited will be a legislator, a trial judge, an appellate judge, and an executive branch social services administrator from each of the 50 states. This model is an example of how judges and legislators can work together to better serve children and their families.

SUMMARY CONCLUSIONS AND FUTURE DIRECTIONS

SUMMARY AND CONCLUSIONS

Margaret M. Hastings, Ph.D.

SUMMARY OF IDEAS PRESENTED

This monograph has presented an overview of the issues in financing mental health services and focused on mental health financing at the federal, state, and local levels. Progress and concerns in funding mental health services from the private sector viewpoint also have been presented.

Financing of mental health services must be seen in a broader context of the society in which those services are delivered. Major external forces impact those services: changes in demographics; social and cultural belief systems; economic conditions; and changes in attitudes of cooperation across agencies and between levels of government. It is appropriate, then, to summarize some of the major points of each section of the monograph.

Substantial changes have occurred in the delivery and financing of mental health services in the past three decades. These financing changes have paralleled advances in psychopharmacology, treatment modalities, and better understanding of brain function. Major changes in public attitudes and concern for human rights have led to significant policy changes through judicial, administrative and legislative action at federal, state, and local levels of government.

A review of statistics over those thirty years reveals that mental illness three decades ago occupied half the hospital beds in America. In 1955, state hospital populations reached a peak census. From 1955 to 1980, the figures dropped dramatically in state facilities at a time of national population growth.

Some major federal legislative policies in the 1960's speeded the rate of deinstitutionalization, including the availability of Social Security payments giving otherwise indigent disabled persons some income protection; the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963; and the 1965 advent of Medicare and Medicaid. Through these programs, states could shift to the federal government some costs for care for the mentally disabled, especially those in the community.

The resulting dramatic shift from state hospitals as the principle care giver is reflected in transition of inpatient care from 77% to 27% of all episodes of mental health care during the period from 1955 to 1975. However, during this same period total patient episodes rose from 1.7 million to 6.9 million.

Multiple Financing Mechanisms for a Service System

Over a few short years these policy and treatment changes have resulted in a variety of financing mechanisms for different components in a comprehensive community delivery system. The result has been multiple financing mechanisms in the public sector at all levels of government. The private third-party payers provide financing for certain populations and some of the needed system of services.

Multiple levels and types of financing have led to diffused responsibility for services, fragmentation in the delivery system, and major unmet needs and underserved populations. Children and adolescents, the elderly, long-term deinstitutionalized chronically mentally ill, young chronic adults, minority populations, and mentally ill persons involved with the criminal justice system are some of the populations for whom special planning, program development and related financing are necessary.

In order to serve specific populations with whatever financing systems have emerged a set of services must be developed. Service systems have been variously defined through legislation at the state and federal level. Availability of a system of services can lead to more appropriate utilization and flexibility to meet the varying levels of need in a given client or population group. These service components should include a comprehensive continuum of prevention, clinical assessment and diagnosis, emergency and crisis care, intensive treatment and rehabilitation, longer term and transitional residential alternatives, case management and maintenance with community support programs (transportation, housing, employment, food, vocational and day programs, etc.).

Financing this set of services becomes the critical issue for mental health. One federal program may finance one or two services in the continuum and state expenditures may provide three or four depending on the severity of the client and/or the service setting to be utilized.

Federal programs provide two basic types of financing: (1) entitlements directly to an individual (e.g. SSI or SSDI) or for a special service to an entitled person (e.g. Medicaid, special education); and (2) grants to states to provide a specific program or set of services (e.g. vocational rehabilitation, social services). Appendix C summarizes basic provisions of these programs.

Generally entitlements provide significantly greater resources than do categorical program funds or block grants. Some reductions and significant consolidation occurred in federal categorical programs to states and local areas in 1981 through OBRA. Any policy decisions to reduce entitlements, then, affect services at the local level where individuals may seek other funding sources from state and local government for essential needs.

Although state statutes vary greatly, state governments most typically provide general revenue funds for state institutions and for some community mental health services and other community support programs. States act as the policy centerpiece for planning, regulating, coordinating and evaluating a system of services. Meanwhile local governments may use local tax monies to supply or augment same or different mental health services than the federal or state programs provide. Other county and local government boards may be elected or appointed to oversee distribution of local as well as some or all of state dollars to that local area. However, local boards do not control major federal entitlement funds to individuals or entitled services for eligible individuals, such as Medicaid. The balance between local/state responsibilities for mental health services varies substantially among states.

In addition to public dollars at the federal, state and local levels, private insurance coverage has evolved for certain services and mental conditions. Mental health benefit coverage has been stimulated by advocacy groups and related to state mandated insurance benefits. However, private insurance has had a bias toward short-term institutional care and, therefore, has been a minimal resource for the more seriously or chronically mentally ill.

Individual perspectives on development of financing streams and the varying needs of populations for mental health services are presented in Section 2 of the monograph.

Shifting Responsibility

The historical shifting of responsibility for the mentally ill between the private and public sectors and between levels of government was the initial focus of Dr. Goldman. As a response to community demands for care at the time of urbanization, in the mid 1800's, state hospitals began to develop as a more humane and consistent source of care than the conditions under which many lived in communities. By the end of the 19th century State Care Acts gave state government total responsibility for the care of the mentally ill and states remained the most powerful centralized public force in financing care of the mentally ill until the entrance of the federal government in the 1900's: first, with the Veterans Administration and soon followed by Title II (OASDI) of the Social Security at in the 1930's. In the 1940's, the private sector entered with restricted separate mental health insurance benefits.

In the 1960's entitlement funding (Medicare, Medicaid, and SSI) created new opportunities for federal financing, but limits also were quickly imposed. Deinstitutionalization became a major national policy direction with the categorical funding of the comprehensive Community Mental Health Centers Act and its federal funding relationship directly with local communities.

During the late '70's a shift occurred back toward state responsibility with the advent of "new federalism" culminating with consolidation of categorical funding in 1981 with the passage of OBRA.

Federal Changes. Current developments in Medicare and SSI/SSDI represent an emerging national policy of controlling rapidly escalating entitlement expenditures. DRG's have been introduced as a prospective payment system for Medicare. Currently most psychiatric beds are not covered by DRG's through an exemption process while a study due in 1985 is done on classification and related cost systems for psychiatric care prospective payment. Such a system to finance prospectively inpatient services for mental illness is being researched to provide more equitable funding than originally introduced in the first DRG system proposal.

A second major funding source under entitlement which provides funding to individuals with more severe and longer term disability is SSI/SSDI, at the federal level. Again, recent attempts to contain escalating costs and suspected abuse have led to large numbers of persons with mental illness being dropped from disability roles, often shifting costs for daily subsistence back to state and local governments. As a result, new legislation in Congress is addressing the need for more effective determination of mental illness disability and regulations around review and maintenance of persons on SSI and SSDI.

State Roles and Expenditures

In contrast, to a focus on policy decisions in financing at the federal level, Dr. Mazade and Dr. Glover presented results of a current study of expenditures in state mental health authorities (SMHA's). The study was prompted by a continuing lack of adequate data on costs and expenditures to facilitate policy decisions at the state level. The study concentrated on expenditures by the SMHA in each state and gathered data specific to children and adolescents, adults and those aged 65 or older, as well as state revenue resources.

Findings of the study indicated that SMHA's controlled and administered, nationally, $6 Billion in funds in FY 1981, approximately 80% of which comes from state government sources and reflects SMHA dependence on the state legislature and its general revenue dollars for funding. Medicaid was found to be the largest contributor of federal program dollars going to SMHA's.

States are spending approximately 70-75% of the SMHA budget on state mental hospitals as opposed to 25% on community-based programs. Although lengths of stay and numbers of beds have decreased substantially in state hospitals, admissions have quadrupled.

The study results highlighted a number of issues in the mental health system, including the differing needs of the sub groups within the definition of "chronic" mentally ill and their varying needs related to treatment modalities.

The increased expenditures for state hospitals with fewer beds reflected the changing role of the state institution. With the attempts at deinstitutionalization, those remaining at the state facilities primarily are more severe or multiply handicapped, sent by the courts, and/or those with difficult behavior management problems. To provide care to this population means higher per capita costs for smaller numbers of beds. Community based waivers (Title XIX) and DRG's (Title XVIII) were seen as providing monetary incentives to states to deinstitutionalize in the future.

Preliminary findings in a related study of two pilot states indicate that monies are being spent in many other state agencies for mental health services and are equal to or greater than expenditures of the SMHA. Identifying these various actors and funding streams in each state will provide a foundation for a more coordinated mental health system with identification of boundaries of responsibility.

The Mazade/Glover presentation provided a current profile of the most enduring of the financing systems: the state mental health agency. Utilization of that agency and its services continues to be impacted by the provisions of mental health insurance in the private sector.

Insurance Perspectives on Mental Health Services

Funding by the private insurance sector has grown and evolved around the existing public system. Major developments in private sector funding were reviewed by Allen Feezor. The emergence of the current structure of mental health benefits coverage provided by non-profit and commercial third-parties emerged after World War II and responded to the advent of general hospital short-term psychiatric units and to office-based psychiatry.

However, many problems have arisen in the administration of mental health benefits. The original design of mental health coverage was geared to short-term institutional and office-based psychotherapy. It was not developed by a direct assessment of mental health service needs of the population. Therefore, benefits need to be reassessed relative to new treatment modalities and alternatives to institutional care.

Another emerging issue is lack of "hard" criteria to review mental health benefit utilization appropriateness, especially non-institutional care. Vagueness of diagnoses and confidentiality further limit systematic review of claims by payers. The situation is further aggravated by new changes in the organization, supply, and delivery of mental health resources in a time of increasing cost constraints. The rate of growth of the mental health community, especially in affluent metropolitan areas, can lead to overutilization.

The criteria for mental health service coverage has been further exacerbated by the rapid expansion of non-traditional mental health settings, giving patients more options and more normalized settings, but also creating at least 100,000 new, potentially reimbursable non-physician personnel.

Another threat to mental health coverage in the future is the growth in the use of mental health resources for more than treatment of illness. Mr. Feezor suggested coverage of services for managing daily life problems and enhancing self-fulfillment, may divert scarce resources from persons in greater need.

Most of all, changes in consumer preferences may challenge most future mental health coverage, especially when coupled with cost-control pressures and economic conditions. To contain costs of benefit packages, purchasers of group benefits will reduce benefits of lesser preference and apply them to more popular coverages, such as some preventive services, well-baby, dental and vision care. Thus, structural and administrative problems are having a cumulative effect on mental health benefit erosion.

Private insurers have some specific concerns for state legislators, as state officials will be major determinants in how mental health services will be delivered in the future. These policy issues include coverage of the non-insured who are not covered even by any state mental health insurance mandate; the need to develop consensus on the difference between insuring "social" problems and serious mental illness; and substantial continuing escalation of mental health claims.

Additional policy areas for legislative review include utilization of coverage by 1% of those covered accounting for 7% to 8% of the cost; continuing cost containment pressures because 38% of industry's labor cost now goes to benefits; and an examination of the relationship between a state's mental health needs and its regulatory licensure and certification standards, so as not to induce excessive capacity. In order to cope with these and other policy questions, in the future insurers should employ more innovation in delivery; benefit design; provider distribution; utilization and peer review; and prior approval in the administration of insurance benefits for mental health services.

Mental Health Benefits in California. From the perspective of a benefits manager for a large state Blue Cross/Blue Shield Plan, Ms. Margaret Kelly identified major trends as well as problems experienced by private insurance in determining which services will be offered in the private insurance arena. Ms. Kelly discussed a new Blue Cross/Blue Shield benefit package in the substance abuse field which encourages the most appropriate, least costly care and provides residential rehabilitation and outpatient care in lieu of hospitalization. This was seen as movement toward responding more effectively to the needs of the insured in reimbursing services as well as satisfying cost concerns.

Blue Cross contracts in California reflect a great variability in the extent of inpatient and outpatient mental health services. Other program benefits offered by California Blue Cross encourage partial day hospitalization in place of inpatient through incentives to physicians and those insured.

A number of payer issues were raised regarding mental health benefit coverage. Blue Cross of California has moved to utilize the concept of eligible provider in order to accommodate the growing number and types of professionals in the mental health field. Evaluating the quality of new, innovative programs continues to be an issue for the payer who must rely on state credentialling and criteria for licensing. Legislation permitting a new program to operate can pass before licensure standards are adopted.

Once again employers are looking to cut costs and questioning the high utilization of mental health benefits by a few for a significant cost to many. California insurers are also concerned about significant growth in the mental health provider community which can result in over-utilization problems.

A final observation reveals the fact that, in the last twenty years, government has invested heavily in new treatment settings and training programs for staffing these settings. These have pushed traditional benefits toward obsolesence and a more rational structure must be developed to take care of diverse populations and their varying needs.

Achieving Adequate Mental Health Benefits. In pulling together both the role of private insurance and the public sector in the provision of mental health services, Mr. Krizay identified deficits currently in private insurance coverage and steps which needed to be taken to improve that coverage. Presently, private sector health insurance does not adequately cover mental illness, especially the chronic patient.

Changes in that policy haven't been made for several reasons. Currently, when hospital per diems are the same for mental health inpatient care as they are for other illnesses, this encourages inpatient utilization by hospitals who often can recover more than their actual expenditures on inpatient psychiatric beds. An additional factor according to Mr. Krizay is that many mental health professionals seemingly are content with the existing minimal levels of insurance coverage for mental illness.

An even greater contributing factor to poor mental illness coverage is public opinion. The public image of the mental health provider can be rather negative, especially resulting from media exposure of forensic cases. This is a requirement for public diagnostic and treatment substantiation not placed on other physicians treating other illnesses. Judicial scrutiny of the mental health provider may lead to skepticism regarding certain treatment interventions.

Mr. Krizay believes mental health coverage is not expensive in the insurance sense. Data indicate that liberal mental health benefits cost half as much as surgery or dental care. It is more reasonable for consumers to insure against mental illness, which is not highly utilized but can be very costly to the individual. Insuring for dental care is predictable and is spread over the entire population. The purpose of insurance should be to serve as protection against unpredictable, costly incidents.

Proposals for securing more adequate mental illness coverage can be obtained through public relations. Benefit packages reflect client preference. The public should be more aware of the potential severity of mental illness, both emotional and economic, on its victims and families. Its duration and effects can be devastating and its incidence, although predictable in an entire population, is random.

A second step toward more adequate coverage is mandating adequate benefits, especially for chronic mental illness. Mandates have worked negatively when they are interpreted as maximums by employers and insurers. The public should be educated as to what comprises adequate coverage.

Legislators also should be educated about the real facts on mental health benefit costs and the potential cost savings to the state by more adequate insurance which could shift many more seriously ill people to the private sector services.

Other steps to insure more adequate coverage might involve development of public and private voucher systems. Consumers should have more control over benefit purchase As another step the general public and professionals should encourage Preferred Providers Organizations (PPO's) as a way to use more efficiently different providers with different skills working together toward a common goal of quality care.

Mr. Krizay concluded his ideas with the fact that treatment of mental illness has always been the step child of the medical system, and yet, by diagnostic category, the care and treatment of mentally ill constitute the largest single category of all services. Mental illness is a disease that will cost the community whether it chooses to finance treatment or deal with the victims through some other welfare or correctional system. From earliest times, mental illness has been seen as a community burden.

Mental Health Fundamentals for State Legislators. Specific lessons from the private sector were presented by Mr. Kipp who also identified seven critical administrative fundamentals and the role legislators play in the development of these critical areas.

The three lessons were presented as powerful tools from which a state legislator or other government official can establish a framework for a financially sound and responsive mental health service system.

First, a careful distinction between jobs programs and mental health services must be made to avoid escalating costs and to develop an effective service system. Second, capital markets should be used to finance public mental health services to a greater extent than at present. And, third, escalating costs of mental health care are fueled by excessive hospitalization. Alternate delivery designs should be developed to reduce the eighty cents on the mental health dollar now going for inpatient care.

From these three basic concepts it is possible to construct some legislative principles for a coherent public mental health program. These principles are largely administrative, but can be the underpinning of an effective system. These principles include using operating data to evaluate performance. Facts are fundamental to effective decision making: if it can't be measured, it won't be managed.

Other principles include integrated management and improved coordination of services within a geographic area in order to prevent expending valuable energy on "wars" between CMHC's and state hospitals, or between state hospitals and county officials. Integrated management between state and local services is critical to long-term mental health care.

The principle of capitation funding for heavy service users (i.e. a type of mental health maintenance organization) and the principle of planning and implementing varying levels of care in state and community facilities are essential planning directions. The important practice of setting limit and priorities for state mental health responsibility in the allocation of resources across populations is critical to operatiang procedures to assure a more successful state system. State legislators and administrators should work to establish a coherent legal framework for effective operation of the mental health system, a major state enterprise.

Mental Health Financing in the Broader Context

The financing of mental health care, then requires adequate policies and a plan to implement the needed service components. Specific populations need different kinds of care which relate to the intensity of the disability, the course of the illness, and the level of possible rehabilitation. Various funding sources have been created that provide for different pieces of the service system and access by individuals to those pieces. However, mental health financing cannot be viewed only from the perspectives of services to be rendered, populations to be served, or funding sources to be utilized. Mental health services financing occurs within a broader context and is impacted by national and global economic forces, changing population characteristics, ethical values and cultural beliefs as well as other environmental conditions.

Planning for Changing Demographics. Changing population statistics are creating an increasing demand for human services. Dr. Kahn identified human services financing as a central domestic issue across humane societies. In recognition of this fact, 1980 figures indicate that 54% of the federal budget and 64% of state and local government budgets went to human services; the state/local percentage has remained relatively stable over the past decade. A major demographic change affecting the demand for human services is the percentage of families in which both parents work; this figure rose rapidly from 40% of all couples in 1960 to 62% in 1981. In addition, 21% of households with children under 18 years are sustained by women, while an estimated 50% of all black families are headed by women. One in 7 white children and 1 in 4 black children in 1979 were born to teenage mothers. These factors are related to the finding that 50% of all poor families in the U.S. in 1982 were headed by women. These factors have significant policy implications related to needs for child care, education, nutrition, housing, medical, mental health and other human services.

Another demographic change at the other end of the life cycle relates to 11% of the U.S. population being over 65 years, a figure which will rise steadily to 18-22% by 2030. With these projections, the demands for long-term care will accelerate. This will require state development of an integrated social service system for long-term care with adequate planning capacity, government taxing power, and ability to develop and use natural settings as well as professional services effectively.

New Service Demands: Long-Term Care. Dr. Wallack addressed specifically the demands for long-term care which deinstitutionalization of the mentally disabled and the burden of increasing costs of nursing home care for elderly have created for service delivery and for fiscal resources at the state government level. Seventy-nine percent of government expenditures for long-term care in FY 1980 went to nursing homes with Medicaid being the chief public payer. Appropriate non-institutional alternatives must be sought. Home health care services, especially for more disabled must be expanded.

State governments must assume primary responsibility for finding workable long-term care solutions. Some of these solutions may incorporate capitation payments to encourage efficient utilization, and insurance or risk-sharing elements must be utilized to develop a revenue pool. Life care communities of 300 to 400 people have successfully pooled assets to provide approximately 20% of residents with nursing care without utilization of medicaid.

Another solution proposed is the Social HMO which operates within the structures of Medicaid and Medicare. In this plan the provider enrolls a mix of clients and provides a full range of acute, rehabilitative, nursing, home health and personal care services under a prospective, fixed budget.

However, the current status of financing for long-term care can be viewed as analogous to acute health care financing 40 years ago. Inadequate financial protection exists, but it is not clear how the void will be filled by public and private financing. The current fiscal problems of federal and state governments are significant, making it unlikely that adequate public financing will be available. Recognition of this reality by public officials should create an environment to encourage private financing and efficient utilization of scarce public dollars in the delivery of long-term care.

Planning and Cutback Management. It is the allocation of resources at a time of increasing demands and falling revenues that was addressed by Dr. Thomas Gilmore. Planning technology, to assist in these difficult human services decisions, was developed during an era of expanding resources. Modifications in the planning process are necessary to adequately address planning needs during periods of economic decline.

"Growth" planning takes place in an environment of predictability with fixed goals to be utilized in efficient allocation. However, "reduction" planning sees the future as unpredictable and goals become less important as efforts simply to maintain current levels of activity take over. Cutbacks are often decisions made quickly, creating anxiety and decreasing motivation for innovative thinking for new projects. During cutback periods, there is need to develop an environment where creative dialog can occur. Yet, in the public sector, this is further complicated by the traditional legislative/executive relationship in decision-making and by high rates of turnover in public sector leadership due to the political process.

Cutback decisions in the public sector can be "across the board" as a less politically difficult strategy, but these decisions often reward inefficiency or penalize effectiveness. An "anatomical" cutback approach can be an opportunity to cut waste and inefficiency. Budget reduction decisions developed from a clear set of priorities produce less anxiety and motivate remaining personnel toward priority areas.

Planning in the public sector and at the state level is often "habit driven" rather than based on a "pro-active", useable and implementable set of directions. Many planning activities, then, take place in a crisis mode rather than preventive one. It is this movement toward effective models for planning on a consistent basis which is critical to resolve many of the problems emerging from new environmental, demographic, and economic factors. A number of planning models for the public sector have been developed to cope with the greater revenue uncertainties, including master planning, comprehensive planning, strategic and contingency planning.

State and Local Perspectives on Service Delivery. Cooperative planning between levels of government and across agencies was the major theme of presentations by Mr. Michael Petit, Mr. Forrest Campbell, and Judge William Jones.

From a state executive perspective, Mr. Petit emphasized the need for aggressive management to increase public and legislative confidence in program administration and to insure efficient use of federal payment mechanisms. Moving toward purchase of services and reducing size of state agencies has brought greater community-based support and increased efficient use of resources in the human services area.

The Governor is crucial in improving human services as the chief executive who has the power to set the state policy agenda, use his or her statewide constituency to gain support, and to use the press effectively in disseminating accurate data relating to human service needs and accomplishments.

Good working relationships across government agencies and branches, especially the state legislature, is critical. Early intervention and prevention programs are seen as essential in the ultimate reduction of human services costs. Special attention should be paid to healthy mothers and babies, as they are the new resources and building blocks for future progress in the lives of citizens.

Mr. Petit concluded by identifying the critical relationship of the state with the federal government by recognizing that seventy cents out of every tax dollar is consumed by the federal government. States can reduce budgets and increase efficiencies but they must receive federal dollars to deal with human service problems. States must provide advocacy for the needed programs related to problems of the poor, mentally disabled, elderly, children, etc. in our society. Allocation of expenditures may be the best expression of our society's collective values.

Emphasis on cooperative planning, once again, was the message of Forrest Campbell and William Jones. Cooperation between all branches and levels of government increase efficiency of both financing and delivery of human services. In North Carolina, a fiscal impact bill has increased cooperative planning between state and local government by requiring proposed costs to be projected before passage of any legislation affecting local government. A Local Government Advocacy Council was also developed to meet with the Governor and Legislature to discuss human service delivery issues and projected longer range needs. Counties and states can benefit greatly from mutual cooperation and such avenues as the local advocacy council for that cooperation must be developed.

William Jones stressed financing and human services issues from the judicial perspective and emphasized two sets of concerns regarding legislative activity: bills passed which impose new responsibilities on judiciary and those which have no funding attached to implement new responsibilities.

Judges want to be more pro-active relative to state legislative efforts and utilize their existing expertise, especially in human service areas. Such collaboration between judicial and legislative branches has led to new programs for children and families in North Carolina. Judge Jones closed by indicating two areas which need substantial collaboration between all three levels of government. One is a cooperative effort on enforcing child support and the second is in permanency planning for children in foster care.

Judicial, legislative, and administrative branches of government must cooperate in developing mutually effective laws, funding mechanisms, and model programs to provide for our neediest children who are the human capital of our future. Investing in these programs can create more stable lives for children leading to a healthier lifestyle and more productive adulthood where, hopefully, fewer rehabilitative resources in mental health and other areas will be needed.

CONCLUSIONS

There are many conclusions that can be drawn when considering various perspectives in the financing of mental health services. Some major themes emerge.

Financing A System of Services

First, creating a system of services in order to respond most effectively to varying levels of client needs is important. Multiple financing mechanisms coexist and, therefore, there is diffused responsibility in creating this needed set of services. This leads to fragmentation and lack of service continuity, especially for the more seriously mentally ill. Some type of coordinated planning for this service system becomes an essential first step in bringing disparate financing mechanisms together more effectively in. This includes serving a community with a full range of services: prevention, crisis and diagnostic assessment, treatment and longer term support systems.

Further, it is evident that lack of consistent or adequate financing has contributed to major gaps in the service system, illustrated by the needs for longer term residential alternatives in the community for more disabled mentally ill.

The service system with adequate financing must also provide for the varying levels of disability and the specific populations needing specialty services. Intensive financing with new models for rehabilitation must be directed act the young adult chronic population now dominating state hospital admissions.

The state hospital's role is evolving, as community services expand and develop greater capacity. State hospitals in the future must concentrate on smaller populations who are the most disabled, multiply handicapped, and difficult to manage in the community. State hospital utilization is directly related to the capacities of community services. Training of staff, adequate program development, and appropriate financing for the more severely disabled in the community are essential if state hospitals are to be phased down and better specialty care provided for those remaining in state institutions.

Capacity and financing is needed for the growing aging populations with high percentages of severe mental disorders. Questions in service capacity remain as to whether sufficient day care, family supports, respite care, and nursing home services can be developed to prevent the most expensive institutional care.

Heterogeneity of target populations has created a need for highly diversified programming and related financing. Existing financing mechanisms do not lend themselves to providing continuity in the care of chronic patients whether they are children, adolescents, young adults or elderly. In addition, fragmentation of services related to diffused financing responsibilities complicate the delivery of comprehensive care, especially to chronically mentally ill.

Payment systems need to be developed related to the client and the level of disability rather than focusing on payment rates for a setting or specific unit of service. More innovative financing mechanisms, such as capitation grants and other pre-pricing systems should be explored, especially for those with more serious mental disability.

Cooperation and Coordination Between Levels of Government

Financing responsibility for the mentally ill has shifted between levels of government over the past 100 years. Clarification is needed in the roles of each level of government to prevent shifting and dumping patients between levels of the system.

The federal level must provide leadership in services research and basic research, technical assistance to states, data collection , knowledge transfer and other information and research functions. With the major federal taxing resources, specific types of maintenance and support programs as well as federal medical programs utilized by the mentally disabled must act in coordination with states.

States are seen as the major coordinator of services and provide the legal framework for service delivery. States must supply leadership in long-range planning, cost containment, quality control, public education and prevention, and evaluation. Further, states must lead in bringing public and private sector resources together to provide a better system of services. Increasingly, states will purchase services from the private sector and must provide financial incentives for most needed community programs as well as for taking more difficult and disabled clients.

Local governments often serve as coordinators for local systems using a variety of funds from state, federal and local public and private sources. In addition, important monitoring and accountability as well as planning must take place at the local level. Another clear theme, then, is that levels of government need to work more cooperatively in the delivery of services, defining roles, and not spending valuable energy on territorial disputes.

- Coordination is essential between levels of government, between the public and private sector, and between agencies of government at each level to finance effectively mental health services. This coordination is facilitated by a shared, larger vision of where the system should be moving. Giving up turf to become more synergistic is mandatory in a period of constrained resources. Setting service priorities for each level of governance creates more efficiency between levels and identifies who is doing what.

If this larger vision with specific goals for services and populations can be identified, then step wise, incremental movement toward these shared goals can be reflected in policy decisions related to funding, minimizing the opportunity for the fragmentation that can result from single special interest advocacy on a specific service funding issue.

A further realization in financing services for the mentally ill is that these populations exist in many agencies and programs across government, including the correctional system, education, public welfare, employment training, rehabilitation, vocational education and the like. This further supports needs, especially at the state level, for coordinative planning efforts.

Private Sector Financing Basic Decisions

Better utilization of private sector resources in financing mental health services is mandatory.

Private insurance has not addressed funding for the more severely ill. Limitations on inpatient stays, outpatient services, and no funding for many of the community support services needed to maintain a person outside of hospital care indicates the continuing institutional bias of private payment systems. Physician practices substantially influence how the private insurance dollar is spent. Most private insurance dollars appear still to be going to acute short-term inpatient general hospitalizations with little support for effective alternatives to hospitalization or for the longer term nature of more severe levels of mental illness.

Insurers have many concerns related to the effectiveness of state mandates for mental health insurance, especially when they identify minimal levels of service which are then interpreted as maximums. Insurers are concerned about what type of parameters to place around the growing numbers of providers and program types. They are looking to state licensure and certification systems to put standards out against which these services can be judged.

Private insurers have difficult decisions to make around the types of services and the populations they will finance. Questions about financing services which enhance self-realization and personal fulfillment rather than funding a range of services for the longer term mentally ill must be answered. These private sector financing decisions will impact public sector resources, as large numbers of insured people are shifted to public sector financing because of limited or inappropriate benefit coverage. Anticipated programs being developed in the private sector for long-term care insurance could have significant impact on the care of chronic mental illness. Affecting insurance policy proposals will be significant in this new area. Once again, allocation, priority setting, and levels of disability emerge as major themes whether in public or private sectors.

External Forces: Cost Control and Increased Demand

Another significant theme is that there are major external forces impacting the financing of mental health services. Major cost controls which are sweeping the entire health system are impacting mental health care. In the private sector, employers are questioning mental health expenditures while consumers are clamoring for more popular coverages leading ultimately to less coverage in mental health services. HMO's are increasingly gaining members and attitudes and biases of their leadership influence the type and/or availability of mental health care. Self-insured corporate benefits fall legally outside of state mandated requirements.

Cost control issues are impacting services with the anticipated movement into mental health care of the DRG prospective payment system forcing more careful diagnostic procedures and short-term treatments in an area where the course of illness and predictability of therapeutic regimens with specific outcomes has been lacking.

One specific financing policy decision has major impact on others. Implementation of DRG's for Medicare hospital reimbursement is creating lower occupancy rates for hospitals, who will downsize bed capacities. However, shorter hospital stays create demands for sub-acute facilities such as nursing homes. Nursing homes have many mentally disabled persons who may in turn be moved to other settings as nursing beds for sub-acute patients are in greater demand. The interrelatedness of systems means that one financing decision either in the public or private sector will have impact on all other financing as attempts are made through multiple financing mechanisms to take care of various populations within the mental health sector. Again, this calls for a more coordinated approach to financing, strategic planning for more finite resources, and careful planning and research around policy development.

Major efforts to control federal entitlement programs are resulting in cutbacks of mental health benefits under Medicaid and support payments through social security disability programs for longer term care of the mentally disabled.

At the same time external economic forces are pressuring for constraints on the system, new population statistics indicate increasing demands for mental health care. Growing numbers of aging, increased rates of poverty among children and single-parent households with young children, accelerating reports of child abuse and family violence, and environmental stress and fragmentation in personal lives suggest that demands for treatment of mental disorders will grow.

Such a finding heralds two major themes. One is that mental health care which was once an issue of building service capacity, has evolved into a serious economic question and related ethical issues around allocation of resources.

Such potential service demands with limited funding support major efforts at prevention. Unfortunately, few resources are currently being spent on prevention programs in comparison to the billions on treatment and long-term care. Prevention policy at all three levels of government must be addressed.

The demand and need for mental health services can be controlled humanely by preventive efforts, not just cost containment measures, so that resources are available for the most disabled and early intervention strategies can be employed to prohibit more severe disabilities. Financing provisions must be developed more comprehensively for prevention and early intervention strategies.

Future Directions

In looking into the future mental health financing will be caught in the same struggles as the overall health and human services system: allocation of finite resources across increased expectations and demand for service. Difficult questions will plague policy makers as to the extent of resources which should be devoted to the most disabled as opposed to those with better prognosis. Steps may be taken to provide a safe, protected environment for those who will not or cannot respond to habilitative regimens. In the future increased numbers of disabled who need intensive care will have dual or multiple diagnoses, such as drug addition and mental illness or substance abuse, retardation and mental illness.

Children must be seen as a major national resource with more attention paid to external forces in their environments, such as pollutants, TV violence, poor prenatal care and nutrition, neglect and abuse, lack of nurturant families and good day care settings, etc. which can be precursors of and risk factors related to mental illness. This potential lost productivity and lifetime demand for care must be seen as a major challenge to human services financing. Further, for those who do need care, natural supports, churches, self-help groups, and voluntarism will be important resources in the future as cost constraints demand alternatives and less costly effective types of care.

The relationship of all the factors in our environment to mental illness will become increasingly important. Policies related to employment, pollution, food additives, alcohol and prescriptive drug consumption, availability of the arts and recreation may be viewed as major factors impacting the need for mental health services financing.

Services research to develop more effective treatment outcomes will become imperative as well as continued emphasis on brain, neurological, and social/behavioral research into causes of mental disorders. Dissemination of these findings must be improved so that impacts on financing policy can be made more quickly and effectively.

Increased resource constraints will place mental health financing in intersectoral competition not only with other parts of the health system but with education, space exploration, defense, etc. Increasingly, challenging choices by policy makers will have to be made between young/old; prevention/casualty; heroic care/adequate care; one class care/two or three classes of care; or industry/environment.

Without a shared vision and basic values these decisions will be difficult. To make these challenging choices, new ideas and ways of thinking will be needed. Jonas Salk has said that survival will be at stake as we move into a new epoch where wholeness, balance, and quality will be more important than absolute, parts, extremes or quantity. Ideas will be as important as genes and wisdom the new criterion of fitness.

Mental health financing will need creativity and vision to meet the demands ahead.

APPENDIX A

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APPENDIX B

GLOSSARY OF TERMS

APPENDIX B
GLOSSARY

Acute - Severe but of short duration; not chronic.

(ADM) Alcohol, Drug Abuse and Mental Health Block Grant - Created by the Omnibus Budget and Reconciliation Act of 1981 (OBRA) to consolidate federal funding programs (The Community Mental Health Centers Act, The Mental Health Systems Act, Sections 301 and 312 of The Comprehensive Alcohol Abuse and Alcoholic Prevention, Treatment and Rehabilitation Act of 1970, Sections 409 and 410 of the Drug Abuse, Prevention and Treatment and Rehabilitation Act) into a block grant to each state. Thee were to be fewer federal requirements placed on states with regard to the use of this block grant money. It was anticipated that state flexibility in the use of funds would increase.

Advocacy - class of activities in support of the interests of service recipients.

AFDC - Aid to Families with Dependent Children (under Title IV-A of the Social Security Act).

Alzheimer's Disease - Disease that produces intellectual impairment and is now recognized as the most common cause of severe intellectual impairment in older individuals. Changes most commonly associated with this disease occur in the proteins of the nerve cells in the cerebral cortex - the outer layer of the brain - leading to an accumulation of abnormal fibers. Scattered throughout the cortex, groups of nerve endings degenerate and disrupt the passage of electro-chemical signals between the cells. These areas of degeneration have a special appearance under the microscope and are called plaques. The larger the number of plaques and tangles, the greater the disturbance in intellectual function and memory.

Behavior Modification - Precisely planned, systematic, application of methods and experimental findings of behavior, including increasing, decreasing, extending, restricting, teaching, and maintaining behaviors.

Block Grant - Although there is no precise definition, in general block grants (1) include a broad range of related activities with less precise purposes; (2) are subject to relatively few federal regulations; and (3) require no federal approval of a plan before money is spent.

Categorical Grant - Although there is no precise definition, in general federal categorical grants (1) include a number of closely related activities focused on a specific set of purposes; (2) are subject to a relatively large number of federal regulations including definitions of eligibility and require services; (3) require some sort of federal preapproval of a plan before money is spent; and (4) are subject to extensive reporting requirements and program audits.

CETA - Comprehensive Employment and Training Act Program - Program administered by the U. S. Department of Labor which provides formula and project grants for training and employment opportunities to the unemployed, underemployed and disadvantaged. CETA was repealed in 1982 and succeeded by Job Partnership Training Act (JPTA).

Child Support Enforcement Program - State/Federal effort to collect child support from absent parents. Although designed primarily to reduce welfare costs by collecting support on behalf of children receiving AFDC, the services of the program are also available to families who are not on welfare. The program is provided for in Title IV-D of the Social Security Act.

Chronically Mentally Ill - Term used to describe a person who suffers certain mental or emotional disorders (organic brain syndrome schizophrenia, recurrent depressive and manic-depressive disorders, paranoid and other psychoses, plus other disorders that may become chronic) that erode or prevent the development of their functional capacities in relation to (three or more of) such primary aspects of daily life as personal hygiene and self-care, self-direction, interpersonal relationships, social transactions, learning, and recreation; and that erode or prevent the development of their economic self-sufficiency.

Most chronically mentally ill people have required institutional care of extended duration, including intermediate-term hospitalization (one year or longer in the preceding five years), or nursing home placement on account of a diagnosed mental condition of a diagnosis of senility without psychosis. Some such individuals have required repeated short-term hospitalization (less than 90 days), have received treatment from a medical or mental health professional solely on an outpatient basis, or, despite their needs, have received no treatment in the professional care service system.

These chronically mentally ill people may include persons who are or were formerly residents of institutions (public and private psychiatric hospitals and nursing homes), and persons who are at high risk of institutionalization because of persistent mental disability.

Community Mental Health Centers - Public or private non-profit legal entity through which comprehensive mental health services are provided to residents of a geographic catchment area.

Community Mental Health Centers Act (1963) - Federal legislation which authorized federal funding for the creation of comprehensive community based mental health centers. Such centers were mandated to provide a specific set of services in a geographic catchment area and could provide other services on a discretionary basis. Federal funding for each center declined over an eight year time period and each center eventually was funded mostly through other sources. The Act was significantly amended by the Mental Health Systems Act of 1980 and repealed by the Omnibus Budget Reconciliation Act of 1981.

Community Support Program - A system of services to meet the needs of chronically mentally ill children and adults, who are capable of living in the community with appropriate rehabilitation and support services.

(CSS) Community Support System - A planning concept developed in 1976 by the National Institute of Mental Health (NIMH) and currently being operationalized by NIMH's Community Support Program. The CSS concept outlines a full range of opportunities and services that meet the needs and develop the potentials of persons with chronically disabling mental health problems who are capable of living in the community with appropriate rehabilitation and support services.

Day Treatment and Partial Hospitalization Program - A program designed to provide individualized therapeutic and rehabilitative care but more than outpatient care. Services are intended for persons making a transition from inpatient care to a less intensive form of care or services, or as an alternative to inpatient care. They are designed to treat mental health problems as well as increase basic coping, social, and vocational skills necessary for successful community functioning. Ideally, programs include evening care, night care, and weekend care.

Deductible - Amounts paid by enrollees for covered services before insurance makes reimbursements.

Deinstitutionalization - With the passage of the Community Mental Health Centers Act of 1963, deinstitutionalization of mentally disabled persons became a national mental health policy. In practice the term refers to preventing unnecessary retention in and admission to public mental hospitals through the timely discharge of admitted patients and the diversion of potential candidates for admission to other treatment services and facilities. (e.g. nursing homes and other community - based residential and ambulatory service setting).

Developmental Disability - Severe, chronic disability which: (a) is attributable to a mental or physical impairments, (b) is manifested before the person attains age twenty-two, (c) is likely to continue indefinitely, (d) results in substantial functional limitations in three of more of the following areas of major life activity: (1) self-care, (2) receptive and expressive language, (3) learning, (4) mobility, (5) self-direction, (6) capacity for independent living, (7) economic self-sufficiency, and (8) reflects the person's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services which are of lifelong or extended duration and are individually planned and coordinated.

(DSM-III) Diagnostic and Statistical Manual of Mental Disorders (3rd Edition) - Official manual of the American Psychiatric Association for classification of mental disorders. The purpose of DSM-III is to provide clear descriptions of diagnostic categories in order to enable clinicians and investigators to diagnose, communicate about, study, and treat various mental disorders.

(DRG) Diagnostic Related Groups - Method for classifying patients into categories on the basis of diagnosis and treatment. This method is utilized in the prospective payment system employed by the federal government to pay for hospital care of medicare patients. The system was begun in October of 1983.

Forensic Inmates - Mental health service recipients whose multiple difficulties, which stem from mental illness, have brought them to the attention of the criminal justice system. The unique feature of service delivery to such recipients (usually designated as not guilty by reason of insanity or unfit to stand trial) is that services must be provided in a setting where movement and freedom is restricted and staff must be specially trained in legal and security issues. Forensic programs function as alternatives to penal incarceration for mentally ill defendants in criminal proceedings.

Group Home - Small community-based residential facility intended for disabled individuals who are capable of living in the community, but whose mental health problems or other disabilities prevent them from living independently. Usually such facilities have a 24-hour staff. They may be designed to provide a variety of types of supervision, support services or rehabilitative services, depending on the needs of those who dwell there.

Guardian Ad Litem - Guardian appointed by a court for the sole purpose of prosecuting or defending lawsuits.

Half-way House - Place where persons are aided in readjusting to society following a period of imprisonment, hospitalization, etc.

HMO Health Maintenance Organization - Organized system for providing health care in a geographic area, which assures the delivery of a set of basic and supplemental health maintenance and treatment services to a voluntarily enrolled group of persons. HMO services are reimbursed through a predetermined, fixed, periodic pre-payment made by or on behalf of each person or family unit enrolled in the HMO without regard to the amounts of actual services provided.

Home Health Agency - Public or private organization providing skilled nursing and other therapeutic services in the patient's home and which meets certain conditions to ensure the health and safety of the individual's furnished services.

Hospice - Specialized home like setting for provision of care to terminally ill patients.

(IMD) Institution for Mental Disease - Any residential facility established primarily to treat the mentally ill.

Intermediate Care - Health-related care and services to individuals who do not require the degree of care or treatment that a hospital or skilled nursing facility is designed to provide, but who, because of mental or physical condition, require 24-hour availability of nursing care and other services (beyond room and board) that can be made available only through institutional facilities. Public institutions for care of people with mental retardation and related conditions are also included.

Learning Disabilities - Disorders of one or more of the basic psychological processes involved in understanding or using language, including such conditions as brain injury, dyslexia and developmental aphasia.

Life Care Community - Residential setting for a group of elderly persons. These communities are privately financed with residents paying an initial entrance fee and monthly fees which cover all housing and medical care costs, except acute inpatient care costs. This alternative for care of the elderly represents a self-insurance model. Entrants are screened so that only a small portion of the community is in need of nursing home care at any given time.

Long-term Care - Health and/or personal care services required by persons who are chronically ill, aged, disabled, or retarded, in an institution or at home, on a long-term basis. The term is often used more narrowly to refer only to long-term institutional care such as that provided in nursing homes, homes for the retarded, and mental hospitals.

Major Medical - Type of health insurance that provides benefits up to a high limit for most types of medical expenses incurred, subject to a large deductible. Such contracts may contain limits on specific types of charges, like room and board, and a percentage participation clause sometimes called a coinsurance clause. These policies usually reimburse for expenses whether an individual is in or out of the hospital.

Matrix Psychiatric Benefit - Psychiatric benefit to be included in the matrix contract to Blue Cross - Blue Shield national account members. The matrix contract was developed so that purchasers of the contract may choose a variety of benefit options.

Medicaid - Federal program which provides health insurance to low-income families who meet certain categorical and financial criteria.

Medicaid Waiver - Provision of Omnibus Budget and Reconciliation Act of 1981 (OBRA) which allowed for a waiver of regulations prohibiting Medicaid reimbursements for certain community-based services. Waivered services must be necessary to prevent institutionalization and cannot include room and board costs.

Medicare - (Title XVIII of the Social Security Act). Part A provides Hospital Insurance Benefits for the Aged and Disabled. Part B is a voluntary program providing supplementary Medical Insurance Benefits for the aged and disabled.

Mental Health Systems Act (1980) - Law extended and amended the Community Mental Health Centers Act. In addition to assistance for community mental health centers, it emphasized assistance for chronically mentally ill individuals, mental health services for the elderly, and an increased role for the states in the delivery of mental health services. The law also made a general provision that states should ensure that mental health patients receive the protection and services they require. This law was repealed by The Omnibus Budget and Reconciliation Act of 1981 and was succeeded by Alcohol, Drug Abuse, and Mental Health Services Block grant.

Old Age, Survivors, and Disability Insurance (Title II of the Social Security Act of 1935) - Federal legislation which was the forerunner of the Supplemental Security Income and Social Disability Insurance Programs.

(OBRA) Omnibus Budget and Reconciliation Act of 1981 - Massive reform of the Reagan Administration to decentralize administration and funding of health and social service programs from the federal to the state level of government. It was felt that states are in the best position to identify the needs of their respective populations; therefore, OBRA put states in a position to play a more substantial role in the decision making process.

Pareto - Vilfredo Pareto (1848-1923) was an Italian economist and sociologist who was the first to observe that 90 percent of the wealth is in the hands of 10 percent of the people.

Per Diem - Amount to be paid for each day of care and treatment.

Permanency Planning - Involves focusing resources of the child welfare system on the child's need for a permanent home. The emphasis is upon efforts to keep a child with his/her family whenever possible; to promptly reunify the family when a child is removed; and to make timely decisions to find children permanent homes when they cannot be returned to their families.

Preferred Provider Organization (PPO) - An association of hospitals and physicians that provides an Alternative Delivery System (ADS) to the health care industry. A PPO is generally limited network of physicians and hospitals that have formally agreed to provide certain health care services to specified insured populations at previously negotiated rates. It is a group of hospitals and physicians which contracts on a fee-for-service basis with large employers, insurance carriers, or third party administrators to provide comprehensive medical services to subscribers.

Elements common to most PPOs are: (1) a provider panel consisting of a limited number of physicians and hospitals; (2) a negotiated fee schedule which typically includes a discount of the fee "customarily" charged; (3) a utilization or claims review system designed to lower long-term health care costs; (4) financial incentives, such as a waiver of deductibles and lower co-payments; (5) rapid processing of provider claims -- typically seven to ten days; and (6) marketed to targeted large employers, trust funds and governmental bodies.

Prospective Payment - Method of determining payments for medical care in advance of delivery of services.

Rehabilitation Act of 1973, Section 504 - This section prohibits discrimination on the basis of physical or mental handicap in every federally assisted program or activity in the country. Employers may not refuse to hire or promote handicapped persons solely because of their disability, and must make reasonable accommodation to the person's handicap. Programs must be accessible to handicapped persons and care must be taken not to isolate them from nonhandicapped program participants. Furthermore, benefits and services may not be denied on the basis of handicap.

Residential Social Model Substance Abuse Treatment Program - Licensure category utilized in California for certain free-standing treatment programs utilizing a social rehabilitation, rather than a medical, model of treatment, and meeting specific licensure criteria.

Short-Term Care - Care and treatment provided for short durations of time; periods usually not exceeding 30 days in length.

Skilled Nursing Facility - An institution which has a transfer agreement with one or more participating hospitals, and which is primarily engaged in providing to inpatients skilled nursing care and rehabilitative services and meets specific regulatory certification requirements.

Social/HMO - Managed system of health and long-term care geared toward an elderly client population. This concept was developed at Brandeis University.

Social Security Disability Insurance (SSDI) - Disability insurance payments to the disabled who have been forced to retire prematurely because of disability but who have contributed through their employment to the disability fund.

Social Services Block Grant - Created by OBRA to consolidate federal assistance to states for social services into a block grant that allows states to use the money for almost any community or social services for virtually any individual or family.

Supplemental Security Income (SSI) - A program of income support for low-income aged, blind and disabled persons, established by Title XVI of the Social Security Act.

State Care Acts - State legislation passed around the end of the 19th century which transferred responsibility for the care and treatment of the mentally ill from the local government to the state government.

Tax-Equity and Fiscal Responsibility Act of 1982 (TEFRA) - One of the most far reaching revenue raising and spending reduction measures ever adopted. In addition to raising $98.3 billion (B) over three years through a variety to tax changes, the measure reduces spending and otherwise modifies numerous federal programs including major health programs.

Willy M - North Carolina children under age 18 who: (1) have serious emotional, mental, or neurological handicaps accompanied by assaultive or violent behavior, (2) are not receiving appropriate treatment or education, and (3) are involuntarily institutionalized or placed in residential facilities, or have conditions requiring such placement. For each child in the class, the state must provide rehabilitation and treatment within the least restrictive and most normal living conditions.

Zero-Based Budgeting - System of budgeting which requires that each new fiscal year's budget be totally rebuilt from a zero level rather than incrementally adjusted from the previous years budget.

APPENDIX B
LIST OF ACRONYMS

ABA - American Bar Association
ADAMHA - Alcohol and Drug Abuse and Mental Health Administration
ADM - Alcohol, Drug Abuse and Mental Health Services
AFDC - Aid to Families with Dependent Children
APA - American Psychiatric Association
BC/BS - Blue Cross and Blue Shield Association
CBO - Congressional Budget Office
CMHCs - Community Mental Health Centers
CMI - Chronically Mentally Ill
DRGs - Diagnostic Related Groupings
FEP - Federal Employee's Program
GAO - General Accounting Office
HCFA - Health Care Financing Administration
HHS - Department of Health and Human Services
HMO - Health Maintenance Organization
IMD - Institution for Mental Disease
MFCC - Marriage, Family and Child Counselors
NACO - National Association of Counties
NASMHPD - National Association of State Mental Health Program Directors
NCJFCJ - National Council of Juvenile and Family Court Judges
NCSL - National Conference of State Legislatures
NGA - National Governors' Association
NGRI - Not Guilty by Reason of Insanity
NIMH - National Institute of Mental Health
OBRA - Omnibus Budget and Reconciliation Act
OCSE - Office of Child Support Enforcement
OJJDP - Office of Juvenile Justice and Delinquency Prevention
OPM - Office of Personnel Management
PPO - Preferred Provider Organization
SMHA - State Mental Health Authority
Social/HMO - Social Health Maintenance Organization
SSDI - Social Security Disability Insurance
SSI - Supplemental Security Income
TEFRA - Tax Equity and Fiscal Responsibility Act

APPENDIX C

INVENTORY OF MAJOR FEDERAL PROGRAMS FOR FINANCING MENTAL HEALTH AND RELATED SERVICES

APPENDIX C
INVENTORY OF FEDERAL FUNDING SOURCES FOR MENTAL HEALTH SERVICES

1. Title XVIII of the Social Security Act - Medicare. C-3

2. Title XIX of the Social Security Act - Medicaid. C-7

3. Title XVI of the Social Security Act - Supplementary Security Income for the Aged, Blind, and Disabled (SSI) C-12

4. Title II of the Social Security Act - Social Security Disability Insurance (SSDI). C-20

5. Developmental Disabilities Assistance and Bill of Rights Act of 1989 C-23

6. Rehabilitation Act of 1973 . . . . C-26

7. Education of All Handicapped Children Act of 1974 (P.L. 94-142). . . C-31

8. Vocational Education Act of 1963 . . . . C-35

9. Elementary and Secondary Education Act of 1965 . . . . C-38

10. The Older Americans Act of 1965. . . . . C-40

11. The Food Stamp Act of 1977 . . . . C-43

12. The Job Training Partnership Act C-46

13. Various Acts Related To The Administration of Veterans Benefits. . . C-51

14. Omnibus Budget and Reconciliation Act of 1981. . . . . C-58

15. Alcohol, Drug Abuse and Mental Health Block Grant. C-62

16. Social Services Block Grant. C-63

17. Preventive Health and Health Services Block Grant. C-71

18. Maternal and Child Health Block Grant. C-74

19. National Housing Act (HUD) C-76

20. Housing Act of 1949 (FmHA) C-79

21. Annual Federal Expenditures for Selected Programs. C-83

Information for this inventory has been developed from many sources. These include information provided by the administrative agencies conducting the programs; Budget of the U.S. Government, Office of Management and Budget; Catalog of Federal Domestic Assistance (1984); Congressional Budget Office Publications and the U.S. Department of Education's Summary of Existing Legislation Relating to Handicapped (1980).

FEDERAL PROGRAM SUMMARY

NAME OF LEGISLATION: Title XVIII of the Social Security Act (Medicare)

STATUTORY CITE: 42 U.S.C. 1395

ADMINISTERING FEDERAL AGENCY: Health Care Financing Administration, Department of Health and Human Services (HHS)

GENERAL AREA OF SERVICE COVERED: Medical insurance

MAIN PURPOSE: To provide hospital insurance protection (Part A) and medical service coverage (Part B) for covered services to persons 65 or above, to certain disabled persons and to individuals with chronic renal disease.

BASIC PROVISIONS: Medicare program covers hospital, physicians' and other medical services for most persons 65 years of age and over, disabled persons entitled to social security cash benefits for twenty-four months, and most persons with end-stage renal disease.

Medicare has two distinct parts:

Part A: Hospital Insurance (HI) covers 90 days of inpatient hospital care in a benefit period (spell of illness). There is no limit to the number of benefit periods an individual can use. An individual also has 60 days lifetime reserve if the 90 days available in a benefit period is exhausted. The HI program covers up to 100 post-hospital days in an SNF if the beneficiary has been certified for such care. The HI program also covers home health agency visits. In 1981, home health no longer required prior hospitalization and the limit of 100 visits was removed.

In 1984 an estimated 29.7 million persons were protected under Part A at a benefit cost of $44.2 billion. For benefit periods in 1984, beneficiaries were responsible for: (1) $356 inpatient deductible; $89/day coinsurance for 61st to 90th inpatient day; $178/day on 60 lifetime reserve days; $44.50/day after 20 days of care in skilled nursing facility. Home health services are paid in full.

Psychiatric care covered by Medicare must always be "active treatment", inpatient care in a psychiatric hospital is further limited to 190 days in a patients' lifetime. No such limit exists for physical care. Psychologists' services are covered when billed as hospital services. Neither services provided in skilled nursing facilities nor services provided in home health agencies are covered by Part A if the treatment is primarily for mental diseases.

Part B: Supplementary Medical Insurance (SMI) is voluntary and requires a monthly premium (1984 - $14.60). State Medicaid programs pay these premiums for persons who qualify for Medicaid and Medicare. SMI provides payments for physicians as well as related services and supplies ordered by physicians; outpatient hospital services; rural health clinic visits; and home health visits. Not covered are drugs, dental care, routine eye examinations, and preventive services.

No intermediate care facility or long-term skilled nursing facility care are provided under Medicare.

Under SMI, the beneficiary is responsible for meeting an annual $75 deductible before benefits begin. Medicare then pays 80% of reasonable charges for covered services. In 1984, an estimated 29.2 million will be enrolled in SMI with benefit outlays estimated at $20.3 billion. There is also a $250 annual limit on psychiatric outpatient care whereas there is no such limit for physical care.

FUNDING: Medicare is the federal medical insurance program provided for in the Social Security Amendments of 1965. Both HI and SMI require cost sharing by the beneficiary. HI requires an inpatient hospital deductible in each benefit period. SMI requires monthly premium and a yearly deductible. Beneficiaries also pay coinsurance on physician fees. Two separate funds pay the costs from the federal government. The HI trust fund is financed primarily through a tax on current earnings from employment covered by the Social Security Act. The SMI trust fund is financed through premiums paid by or on behalf of enrolees and by the Federal government general revenue funds. In 1984, expenditures for Parts A and B were approximately $64.5 billion.

ELIGIBILITY: Medicare serves nearly everyone over 65 who either turned 65 before 1968 or who turned 65 after 1968 and is eligible for Social Security benefits or has some work credit. Also eligible are certain disabled persons and those who have chronic kidney disease and require dialysis or transplant.

BRIEF LEGISLATIVE HISTORY: The 1980 Medicare Amendments removed the 100 visit limitation on home health care visits as well as eliminated the three day hospitalization requirement for home health services. The law also provided Medicare coverage for alcohol detoxification facility services certified by a physician as required on an inpatient basis. Medicare Part B coverage was expanded to cover outpatient surgical services. The $100 limit on physical therapy services was raised to $500.

The Omnibus Budget Reconciliation Act (OBRA) of 1981 was responsible for several changes in the Medicare system.

OBRA affected Medicare reimbursements to hospitals for routine inpatient care by limiting it to 108% rather than 112% of median costs. The

Medicare reimbursement limit for home health visits was reduced from 80% to 75% and the need for occupational therapy was no longer necessary to receive home health care.

In 1982 the Tax Equity and Fiscal Responsibility Act (TEFRA) passed. In addition to raising $98.3 billion over three years through many tax changes, the Act reduced spending, and otherwise modified several federal programs including Medicare and Medicaid. Of the numerous changes made in Medicare, the most significant are limits set on inpatient care reimbursement and the mandate for a prospective payment plan.

TEFRA created a system of grouping hospitals and then limiting the costs for which Medicare will reimburse a hospital based on the deviation of those costs from the average of comparable costs for all hospitals in the same grouping. For FY 85, the Medicare program will not reimburse a hospital for costs that are greater than 110% of the average costs for the service for hospitals in each group.

One of the provisions of TEFRA was that the Department of Health and Human Services consult with the Senate Committee on Finance and the House Committee on Ways and Means to develop some system of prospective payment. This system was mandated for hospitals, skilled nursing facilities, and other providers for whom prospective payment is possible. In 1983 a prospective payment system for paying for hospitalization according to preestablished rates for each of 467 diagnosis related groups (DRGs) was begun under Medicare. Rates for DRGs are now based on diagnosis and treatment modifiers such as medical or surgical management rather than the previous system of paying for services rendered. Psychiatric hospitals are currently exempt from the system, however, a general hospital must request an exemption for its psychiatric unit.

On July 18, 1984, the Deficit Reduction Act of 1984 (DEFRA) was signed into law. This bill simultaneously increases revenue while seeking savings in entitlement programs in order to reduce the federal deficit. This bill attempts to decrease the deficit by $63 billion (B) over the next three years by generating $50 B in new revenues and cutting $13 B from entitlement programs. Medicare is one of the numerous programs affected by DEFRA. The actual changes are discussed below.

Certain provisions of DEFRA establish a national fee schedule for all laboratory services provided to Medicare beneficiaries. The fee schedule is set initially at 60% of the prevailing charges for independent laboratories and 62% for hospital laboratories. DEFRA also freezes the reimbursement for customary and prevailing charges for physician service at the FY 84 level for the period beginning July 1, 1984 and continuing through September 30, 1985.

DEFRA also extends the previous law which allowed Medicare to be a secondary payor for workers and their spouses aged 65 to 70, who are covered by an employer's health group insurance and extends the role of Medicare as secondary payor to spouses aged 65 to 70 of workers under 65 whose employer's group health insurance covers such spouses. Other provisions extend the requirement which fixes the portion of Medicare Part B costs and redefines what services can be considered emergency room service.

DEFRA also reestablishes reimbursement rates for free standing skilled nursing facilities (SNF) in rural and urban areas at 112% of the mean cost of the average per diem cost of hospital based SNF's. Another provision expands the definition of "medical and other health services" to include the services of a clinical psychologist when furnished pursuant to a risk sharing arrangement with an HMO.

Other DEFRA provisions which change the Medicare Program include: changes in reimbursement for preadmission diagnostic testing; placing a floor on the customary charges of teaching physician at 85% of the prevailing charge; excluding temporarily cost of anaesthesia service furnished by a certified nurse anaesthetist; restricting reimbursement for capital upon the change of ownership of a skilled nursing facility and providing coverage for hepatitis B vaccine for high and intermediate risk individuals.

FEDERAL PROGRAM SUMMARY

NAME OF LEGISLATION: Title XIX of the Social Security Act (Medicaid)

STATUTORY CITE: 42 U.S.C. 1396

ADMINISTERING FEDERAL AGENCY: Health Care Financing Administration, Department of Health and Human Services (HHS)

GENERAL AREA OF SERVICE COVERED: Medical assistance to the needy

MAIN PURPOSE: To ensure that the basic medical needs of the nation's needy are met. The specific objectives of the program are to provide financial assistance to states for payments of medical assistance on behalf of cash assistance recipients and, in certain states, on behalf of other medically needy.

BASIC PROVISIONS: Medicaid is a federal-state partnership program. In order to receive federal reimbursement, each state must have an approved Medicaid plan and comply with federal regulations. Although states have broad discretion in designing programs, they must follow federal guidelines regarding basic eligibility, services offered, equal treatment, comparability of service and choice of service providers.

States must provide the following coverage for mandatory services to the categorically needy:

Inpatient hospital services (including psychiatric units, not including institutions for tuberculosis (TB) or institutions for mental disease (IMD)).

Outpatient hospital services and rural health clinic services (including services provided by psychiatric units of general hospitals and by qualified psychiatric hospitals).

Laboratory and x-ray services.

Skilled nursing facility services for those 21 and over, not including TB and IMD's. Federal Medicaid law specifically excluded reimbursement for the care of the mentally ill between 21 and 64 in institutions for mental disease. Home health care services for individuals eligible for skilled nursing services.

Early and periodic screening, diagnosis, and treatment (EPSDT) services for those under 21.

Family planning services and supplies.

Physician's services (including psychiatrists' services).

For the medically needy, states are required to provide any seven of these services for which Federal financial participation is available.

State coverage optional services include:

- Psychological tests and examinations by licensed practitioners.
- Private duty nursing.
- Clinic services (may include Community Mental Health Centers (CMHC's).
- Dental services.
- Home Health Care Services.
- Physical, occupational and speech therapy.
- Drugs, eye glasses.
- Rehabilitation services.
- Inpatient psychiatric care for the aged and persons under 21 years.
- Skilled nursing facility (SNF) care for those under 21.
- Intermediate care facility (ICF) (may include ICF for mental retardation and developmentally disabled).

Custodial, domiciliary, residential or educational institutions for mentally ill individuals (whether called hospitals, nursing facilities, schools, homes, etc.) are not covered by Medicaid. However, under certain conditions and for specific populations, as listed above, Medicaid can cover long-term private sector care beds as well as certified beds in state-operated facilities for the mentally ill.

FUNDING: Medicaid is a state administered program which is federally co-financed from 50% to 78% on the basis of each state's per capita income and the state's medical assistance expenditures. "Neediest" states receive the highest rate of federal reimbursement for Medicaid expenditures. (There is no total dollar limit to federal Medicaid matching funds.) Federal funds must go to a certified state welfare agency. Estimated federal expenditures for Medicaid in 1984 are $20.2 billion. The range of financial assistance to states is from $14.8 million to $3.6 billion.

ELIGIBILITY: Those eligible for Medicaid funds fall into two groups; the categorically needy and the medically needy. The categorically needy include recipients of other welfare programs (AFDC, SSI) that is, the needy who are aged, blind, disabled, or members of families with dependent children, or certain children under 21. States have more discretion in defining the medically needy. These may include the aged, blind and needy, and the disabled with income and resources too high to qualify for other federal programs. Eligibility is determined by the state in accordance with federal regulations. Estimated recipients nationwide in 1984 are 22.7 million persons.

BRIEF LEGISLATIVE HISTORY: Before 1935, medical assistance for the needy was a State responsibility, largely met by local government and private charity. The Social Security Act of 1935 provided for federal public assistance for the first time in the form of unconditional money payment for the "categorically needy." The Social Security Act was amended in 1950 to provide for direct (vendor) payments to hospitals and physicians for services to "categorically needy." The 1950 amendments also encouraged states to participate in the program on a cost-matching basis. The Kerr-Mills Act of 1960 provided for more generous federal matching with no ceiling on federal funds, and established the "medically needy" category, for those not necessarily receiving cash assistance. The Social Security Amendments of 1965 established Medicaid and Medicare. Medicaid carried over many of the provisions of earlier legislation (i.e., federal-state partnership, categorical recipient groups, vendor payments).

In 1967 Congress added an early and periodic screening, diagnosis and treatment (EPSDT) program for eligible persons under 21. In 1972, amendments to the Medicaid program included provisions to: control costs, improve administration, expand scope of services, improve service delivery, improve long-term care services, improve utilization review program, and establish Professional Standards Review Organizations (PSRO's).

A Medicaid eligibility quality control program was established in 1975 and expanded in 1978. Based on a quarterly showing reviewed by Health Care Financing Administration (HCFA), it is determined whether each state has an effective and valid quality control Medicaid program. A state may be penalized if it does not have such a program. In order to detect serious misuse of Medicaid by providers, the Fraud and Abuse program was established in 1976.

In 1981 The Omnibus Budget Reconciliation Act (OBRA) made substantial changes in Medicaid. Its provisions included a reduction in payments to states for 1982, 1983 and 1984. However, states could diminish these reductions by implementing certain fraud and abuse programs. Reimbursement provisions for hospitals were changed so that reasonable cost determinations are now made by the state on the basis of cost finding methods approved and verified by HHS. The authority is now the same as that for determining reasonable costs for skilled nursing facilities and intermediate care facilities. OBRA also provided for waivers of Title XIX provisions. First, free choice of medical vendor requirements can be waived so that the state may contract with certain providers and make other restrictions on providers. Second, a waiver is available so that home or community-based services that are federally approved and provided according to a plan of care can be provided to individuals in lieu of more expensive services of skilled nursing facilities or intermediate care facilities that could otherwise be necessary.

In 1982 the Tax Equity and Fiscal Responsibility Act (TEFRA) passed. This piece of legislation was responsible for raising $98.3 billion (B) over three years through tax changes as well as reducing spending by modifying federal programs including Medicaid. Among the changes made to

Medicaid was the institution of a co-payment system. This system allowed states to impose nominal co-payments on all Medicaid beneficiaries for most Medicaid services. Exceptions to this provision include services for children under 18, pregnancy services, emergency services, and HMO services.

TEFRA also allowed states to impose liens on the real property of individuals who fall into one of the following three categories: 1) patients in a medical institution; 2) those required to spend all but a minimum amount of their income for the cost of medical care; and 3) those who cannot reasonably be expected to be discharged from a medical institution and return home.

Finally, TEFRA limited to 3% the rate of erroneous excess payments for which the federal government would make payments to states. However, waivers of this restriction can be obtained if states can show they have been unable to reach the allowable error rate despite a good faith effort.

In 1984, the Reduction Act of 1984 (DEFRA) was signed into law. This bill simultaneously increases revenues while seeking savings in entitlement programs in order to reduce the deficit. Numerous changes in the Medicaid program occur under DEFRA, including an expansion of coverage for pregnant women, children, and newborns and a provision which returns grant payments to the state to the pre-OBRA level. Other provisions include nursing home patient recertification, HMO's, and psychiatric services. These are described below.

Medicaid Coverage for Pregnant Women and Young Children (Child Health Assurance Program CHAP). *Medicaid coverage for pregnant women and young children will be expanded.* "Categorically needy" coverage, at the regular federal matching rate, will be extended to the following groups meeting AFDC income and resources requirements: 1) first time pregnant women; 2) pregnant women in two-parent families where the principal breadwinner is unemployed, and 3) children born on or after October 1, 1983, up to age five, in the two-parent "Ribicoff" families.

AFDC Work Transition Allowance and Medicaid Coverage. States are *required to provide nine months of Medicaid coverage to families* who lose their AFDC eligibility due to a marginal increase in income from employment. States will then have the option of extending coverage for an additional six months if these families were eligible for AFDC had the disregard been applied.

Clarification of Medicaid Entitlement for Certain Newborns. This *provision states that a child born to a woman eligible for and receiving* Medicaid is eligible for one year as long as the mother remains eligible.

Recertification of Need for Stays in SNFs and ICFs. Medicaid patients in *SNFs will have to receive a recertification of need* for continuing care

30, 60, and 90 days after admission, and every 60 days thereafter. Patients in ICFs will have to receive a recertification 60 and 180 days after admission; at 12, 18, and 24 months after admission; and annually therafter. Effective July 1, 1984, there will be no penalty concerning the physician recertification requirement in SNFs and ICFs. However, the legislation does stipulate that the Department of Health and Human Services (HHS) is responsible for developing and enforcing standards governing the provision of care to Medicaid patients in these facilities.

Waivers of Certain Membership Requirements for Certain HMO's. Health and Human Services (HHS) may waive the requirement that HMO's participating in the Medicaid program cannot have a Medicare/Medicaid beneficiary membership that exceeds 75 percent of their total enrollment. HHS may waive this requirement for public HMO's if HHS determines that special circumstances warrant an exception, and the HMO is taking steps to enroll non-Medicare/Medicaid beneficiaries. Under certain circumstances HHS may also waive the 75 percent requirement for a private HMO.

In addition, DEFRA allows states to restrict the freedom-of-choice of persons enrolled in HMOs in a limited way. Under this new provision states may require beneficiaries who choose to enroll in an HMO to remain in that HMO up to six months, unless he or she has good cause to disenroll before that time.

Payment for Psychiatric Hospital Services. The current law calls for special reimbursement limitations to apply regarding problems that may arise with hospital inpatients who are awaiting nursing home placement. DEFRA delays the imposition of these limitations until July 1, 1985 with respect to public psychiatric hospitals. Also, the amount of rate reduction previously required was lowered by one-third for June 30, 1986 and two-thirds for June 30, 1987.

Other areas covered in the bill include: requirement for medical review and independent professional review; flexibility in setting payment rates for hospitals furnishing long-term care services under Medicaid; and Medicaid clinic administration.

FEDERAL PROGRAM SUMMARY

NAME OF LEGISLATION: Supplementary Security Income for the Aged, Blind, and Disabled (SSI) Title XVI of Social Security Act

STATUTORY CITE: 42 U.S.C. 1381

ADMINISTERING FEDERAL AGENCY: Social Security Administration of the Department of Health and Human Services (HHS)

GENERAL AREA OF SERVICE COVERED: Unrestricted income assistance

MAIN PURPOSE: To provide income assistance to the nation's needy aged, blind and disabled.

BASIC PROVISIONS: Supplementary Security Income (SSI) is a federally administered income assistance program. Recipients of SSI must be 65 or older, or blind, or disabled and have incomes and assets below a certain level regardless of work history. SSI benefits are unrestricted direct cash payments to the individual. There is no limit to the length of time an individual may receive SSI benefits as long as eligibility criteria are met.

Disability is defined, for purposes of SSI eligibility, as the inability to engage in "substantial gainful activity" (SGA) due to a medically determinable physical or mental impairment. A disability is further defined as an impairment that may either cause death or last for at least 12 months. Mental as well as physical disability must be evaluated in terms of demonstrable clinical signs. In the case of mental disorders, these signs must be observed during a mental status exam. The subjective nature of this type of evaluation, and the difficulty inherent in predicting on-going functional capacity of individuals with certain kinds of mental disorders from one visit make this kind of evaluation subject to criticism. Mental impairments that qualify for SSI include chronic brain syndromes, functional psychotic disorders, functional nonpsychotic disorders, and mental retardation.

Since in most claims of mental disability functional capacity is reduced, it must be determined if the individual is capable of substantial gainful activity. This determination is made on the basis of an individual's capacity to understand, to carry out and remember instructions, to handle supervision, co-workers, and normal work pressures, and whether he is able to engage in substantial gainful work that exists in the national economy. A person is considered able to engage in SGA when they are able to earn the SGA average earnings limit. (As of 1980 this limit was $300 per month.)

Payments are cut by one-third if the recipient lives in another's household and receives in-kind maintenance and support. This provision has been seen as anti-family and as promoting placement of recipients in foster care or other care facilities where full benefits and a state supplement, where available, will be paid.

FUNDING: Although SSI is federally funded out of General Revenue funds, states may supplement SSI payments in two instances. First, if recipients were transferred to SSI from state assistance programs which were previously in place, the state is required to supplement their benefits so that they are equal to the December, 1973 income level of those recipients (mandatory minimum state supplement recipients). Second, states may opt to supplement SSI payments across the board as a way to cover the cost of necessities for recipients, thereby keeping people in their homes and out of nursing homes where Medicaid would cover basic maintenance costs.

States may also place further restrictions on eligibility for SSI, by making the standards of income, blindness, age and disability more stringent. Therefore, eligibility for SSI makes an individual automatically eligible for Medicaid except where more stringent state SSI standards have been imposed.

In FY 1983 the average federal monthly benefit paid was $180. In 1984, the estimated $191 average monthly payment was received by an average of 3.97 million recipients at a cost of $7.42 billion.

ELIGIBILITY: In order to receive SSI as of January, 1984 income for a single person must be below $314.00 per month and below $472. for a couple (both persons must be aged, blind, or disabled). Resources must not be valued at more than $1,500 for a single person and $2,250 for a couple. When determining income eligibility, the first $20 of unearned income and the first $65 of earned income plus 1/2 of the remainder of earned income are excluded from countable income. This is intended to prevent SSI from being a work disincentive for the disabled. Resources that are excluded when determining eligibility include an individual's home, car, household goods, personal effects, and burial expenses. If a disabled individual is an alcoholic, receipt of SSI is further contingent on undergoing appropriate treatment if available. Blind and disabled adults under 65 are also required to accept Vocational Rehabilitation services to receive SSI. No benefits are made for months or days prior to application.

BRIEF LEGISLATIVE HISTORY: 1972 Amendments to the Social Security Act created SSI to replace federal grants-in-aid programs for needy aged, blind, and disabled.

Since it became clear prior to implementation that some states would not supplement the federal payments as was intended by Congress, P.L. 93-66 in July of 1973 mandated state supplementation so that income levels of recipients under the new program would not drop. Noncompliance by states meant loss of Medicaid funds.

P.L. 93-368 passed in August of 1974 provided for cost-of-living adjustments which raised the level of income of SSI recipients. In light of the raised income, state's obligation to provide mandatory supplementation was reduced or eliminated. For states that did not pass federal cost-of-living arrangements, the optional supplementary payment amount was reduced by the amount of federal SSI increase.

Again in 1976 Congress addressed state supplementation in P.L. 94-585. This law required that states maintain their supplementary payment so that recipients benefited from the cost-of-living adjustments. Noncompliance would result in ineligibility for federal Medicaid funds.

The Keys Amendment of 1976 aimed at preventing SSI from funding substandard housing by requiring states to establish, maintain, and enforce standards for all categories of institutions. The consequences of standards not being met were that the recipient living there would either lose payments because of suspension or get reduced payments. The Amendment also provided that a recipient's benefits would be reduced by the amount of any state payment for medical or remedial care received as an inpatient. The provisions of this bill were difficult to enforce, the penalty was unrealistic and undermined its own intention of stopping exploitation of the aged, blind, and disabled.

The Social Security Disability Amendments of 1980 (P.L. 96-265) liberalized SGA earning limits by allowing deductions for earnings of impairment-related work expenses, and adding a 15-month re-entitlement period to the 9-month trial work period. The bill also extended benefits beyond the point where the individual's income is equal to the federal benefit rate in some cases.

P.L. 92-603, which established SSI, permitted states to determine who would administer supplementary payments program. States could opt to have the SSA administer both or either of the optional and mandatory supplementary programs. Or, states could choose to administer both programs themselves, incurring the cost of administration, but retaining a degree of discretion as to SSI use for certain needs and circumstances. As of April 1983, the SSA makes the state supplementary payments for 22 states and the District of Columbia. Four states administer their own optional supplements.

1984 SIGNIFICANT AMENDMENTS: The following changes were made by the Deficit Reduction Act of 1984: increase of resource limits, limit on overpayment recoupment rate, waiver of overpayments due to excess assets in certain cases, exclusion of retroactive SSI and OASDI checks from countable resources, adjustment of SSI and OASDI benefits to account for retroactive benefit payments, and exclusion of Alaskan bonus payments.

The provisions adopted in the Deficit Reduction Act of 1984 (DEFRA) increase the current SSI countable assets limit for an individual by $100 each January (starting in 1985) until January of 1989. Similarly, the current asset limit of $2,250 for eligible couples increases by $150 each year until it reaches $3,000. DEFRA also places limits on the monthly amount the Social Security Administration can recover on any SSI overpayment except in those cases where the individual has committed fraud. Under this Act retroactive SSI checks are excluded from countable income up to six (6) months after the month in which payment is received.

The Social Security Disability Benefits Reform Act of 1984 made major amendments applying to both SSI and SSDI programs. The sections of the 1984 Act have been summarized due to their importance and vast scope.

SECTION 2 - Standard of Review for Termination of Disability Benefits and Periods of Disability

SSA may terminate disability benefits on the basis that the beneficiary is no longer disabled only if there is substantial evidence there has been medical improvement in the individual's impairment and that the individual is now able to engage in substantial gainful activity (SGA).

Benefits may also be terminated if substantial evidence consisting of new medical evidence and a new assessment of the person's residual functional capacity show that he is able to perform SGA. A beneficiary may also have his SSI or SSDI terminated if there is substantial evidence that the person's impairment is not as disabling as it once was considered to be at the time of the prior determination and therefore the person is able to perform SGA.

Benefits may also be terminated if there is substantial evidence showing the prior determination was in error or the original decision was fraudulently obtained or if the individual is engaging in SGA and fails without good cause to cooperate in the review process. This Act provides for a continuation of benefits during the appeal for all continuing disability review cases through the decision of the administrative law judge and requires SSA to promulgate regulations within six (6) months after this bill's enactment for determining the frequency of the continuing eligibility review.

SECTION 3 - Evaluation of Pain

A temporary statutory standard was established through December 31, 1986 for using subjective and objective evidence in evaluating cases involving pain or other symptoms. This standard reflects SSA's current policy for evaluating symptoms, including pain. This section also requries the Secretary to appoint a Commission on the Evaluation of Pain to conduct a study, in consultation with The National Academy of Sciences, concerning the evaluation of pain in determining whether a person is disabled under the Social Security Act.

SECTION 4 - Multiple Impairments

This provision is intended to ensure that the combined effect of multiple impairments is considered throughout the sequential evaluation process. It requires that the combined effect of all impairments be considered without regard to whether any one impairment would be severe if considered separately.

SECTION 5 - Moratorium on Mental Impairment Reviews

This action by Congress delays periodic review of mentally impaired individuals until criteria for evaluating mental disorders are revised to realistically evaluate the ability of a mentally impaired person to engage in SGA in a competitive workplace. This section reflects the concern of Congress that some claims involving mental impairments have not been adjudicated properly in the last few years and that the criteria for evaluation needs to be updated.

SECTION 6 - Notice of Reconsideration; Prereview Notice; Demonstration Projects

This section requires Social Security or SSI disability beneficiaries to notify any persons whose case may be selected for periodic review as to the nature of the review, any consequences that may result for a review, and his rights in the review process. This provision also requires various demonstration projects to be implemented to test the advantages of a face-to-face meeting requirement between claimant and decisionmakers during the initial stages of the adjudicative process.

SECTION 7 - Continuation of Benefits During Appeal

An extension was made concerning the temporary provision for Social Security disability insurance benefits. This provision permanently provides that SSI disability recipients whose impairments are determined to have ceased, not to have existed or to be no longer disabling, may elect benefit continuation up to the ALJ decision. The intent of the provision is to prevent undue hardship to beneficiaries who are found to be still disabled on appeal.

SECTION 8 - Qualifications of Medical Professionals Evaluating Mental Impairments

Every reasonable effort must be made to insure that a qualified psychiatrist or psychologist evaluate medical impairment cases to assure accurate decision.

SECTION 9 - Consultative Examinations; Medical Evidence

The Secretary is required to prescribe within six months after enactment regulations covering (1) standards for deciding when a consultative examination should be obtained, (2) standards for the type of referral to be made, and (3) monitoring procedures for the consultative examinations and the referral process.

This provision also requires that the Secretary make every reasonable effort to obtain evidence from a treating physician before evaluating medical evidence obtained on a consultative basis.

SECTION 10 - Uniform Standards

A publication of regulations setting forth uniform standards for Social Security and SSI disability determinations under the Administrative Procedure Act (APA) rulemaking procedure, which would be binding at all levels of adjudication is required. This provision is intended to insure public participation in the disability policymaking process (although HHS now voluntarily complies with the APA rulemaking process) and uniform decisionmaking at all levels of the disability adjudication process.

SECTION 11 - Payment of Costs of Rehabilitation Services

There are now several additional circumstances under which states are reimbursed for vocational rehabilitatioN (VR) services provided to Social Security and SSI disability beneficiaries. Reimbursement would be provided in the case of two sets of beneficiaries. The first set is those who medically recover but continue to receive disability benefits because they are participating in a VR program which increases the probability that they will be permanently removed from the disability rolls. The second set is those who refuse, without good cause, to continue to accept VR services or fail to cooperate and thus preclude successful rehabilitation.

SECTION 12 - Advisory Council Study

The next Advisory Council on Social Security is required to study and make recommendations on the medical and vocational aspects of disability. Task forces of experts should e used when appropriate.

SECTION 13 - Qualifying Experience for Appointment of Certain Staff Attorneys to Administrative Law Judge Positions

The Secretary is required to submit a report on actions that have been taken to establish positions enabling SSA staff attorneys to acquire sufficient qualifying experience to compete for ALJ positions. This report must be submitted to the House Ways and Means Committee and the Senate Committee on Finance within 120 days of enactment.

SECTION 14 - Supplemental Security Income Benefits for Individuals Who Perform Substantial Gainful Activity Despite Severe Medical Impairment

The temporary authority in Section 1619 of the Social Security Act that continues SSI benefits and Medicaid for disabled recipients who engage in SGA despite their impairment was extended through June 30, 1987.

SECTION 15 - Frequency of Continuing Eligibility Reviews

The Secretary is required to promulgate regulations within six months after enactment which establish the standards to be used in determining the frequency of periodic eligibility reviews.

SECTION 16 - Determination and Monitoring of Need for Representative Payee

The Secretary is required to evaluate the qualifications of prospective representative payees either prior to or within 45 days following certification. A system of annual accountability monitoring must be established for cases where payments are made to a person other than the entitled individual or his parent or a spouse living in the same household. A periodic verification should be made that parent and spouse payees who have been living in the same household as the beneficiary continue to do so.

The Secretary is permitted to establish a separate accounting system for state institutions for the mentally ill and mentally retarded which serve as payees. Federal institutions which serve as payees are exempt from accounting.

SECTION 17 - Measures To Improve Compliance with Federal Law

Within six months of finding that the state is failing to follow Federal law and agency guidelines in making disability determinations, the Secretary is required to assume the functions of a State Disability Determination Service (DDS).

SECTION 18 - Separability

The constitutional invalidity of any provision of the bill does not affect the other provisions of the bill.

NONACQUIESCENCE: STATEMENT OF MANAGERS

The absence of a provision in the bill is not to be interpreted as approval of nonacquiescence as a general policy. It was urged by the conferees that the policy of nonacquiescence be followed only where the administration intends to take the steps necessary to get the issue reviewed by the Supreme Court

FEDERAL PROGRAM SUMMARY

NAME OF LEGISLATION: Social Security Disability Insurance (SSDI), Title II of Social Security Act

STATUTORY CITE: 42 U.S.C. 420

ADMINISTERING FEDERAL AGENCY: Social Security Administration, Department of Health and Human Services

GENERAL AREA OF SERVICE COVERED: Entitled worker's disability insurances

MAIN PURPOSE: To replace part of the earnings lost because of a physical or mental impairment severe enough to prevent a person from working.

BASIC PROVISIONS: SSDI entitles workers to direct monthly payments who have held jobs and contributed to the Social Security System and who have been disabled. Payments begin after a 5-month waiting period from the onset of the disability and are not restricted in use. Vocational rehabilitation services may also be covered by SSDI. Disability is defined, for SSDI, as it is for SSI eligibility, as the inability to engage in substantial gainful activity (SGA) due to medically determinable physical or mental impairment that may either cause death or last for 12 months.

No asset eligibility applies for SSDI, but income is limited by an SGA earnings test. SSDI is not available to convicted felons in corrections facilities unless they are participating in an approved rehabilitation program which will result in the individual achieving substantial gainful activity. Benefits are not affected by the beneficiary's residential setting as with SSI, nor are they lowered by earning income lower than the SGA standard. However, SSDI payments will stop after a trial period during which an individual is earning the SGA. If the disability reoccurs and earnings fall below SGA within twelve months, the individual is automatically re-entitled. There is no waiting period for re-entitlement if the disability reoccurs between 1 and 5 years. After 5 years, the five-month waiting period applies. Upon reaching 65, a disabled worker's benefit is converted to a retirement benefit.

As of January 1984, the average payment to an individual was $440 per month. The average payment to a worker with eligible dependents was $841 per month.

FUNDING: SSDI is provided to the individual from the federal Disability Insurance Trust fund. It is administered through states' departments on rehabilitation according to rules and regulations set down by the Social Security Administration. It is funded through the Social Security Trust Fund. This program has no statutory formula or matching requirements. Benefit payments in 1983 were $17.5 billion. It is estimated in FY 1984 that an average of 3.8 million disabled workers and their dependents will receive monthly cash benefits.

ELIGIBILITY: A disabled worker under age 65 is eligible if he has worked for a sufficient period of time under Social Security to be insured. The insured status requirements depend on the age of applicant and the date (s)he became disabled.

Chart A

QUARTERS NEEDED TO QUALIFY FOR SSDI

AGE	QUARTERS WORKED	WITHIN
16-24	6	3 Years
24	8	4 Years
25	10	5 Years
26	12	6 Years
27	14	7 Years
28	16	8 Years
29	18	9 Years
30	20	10 Years
31-65	20	10 Years

SSDI eligibility for disabled individuals under 65 is defined by minimum quarters worked requirements in a certain number of years depending on age. (See Chart A) For the chronically mentally ill who often have a sketchy work history, this requirement poses a great obstacle to receiving SSDI benefits. Retroactivity of benefit payments is limited to one year before filing.

Certain family members of disabled workers are also eligible for SSDI benefits. These include:

- Unmarried children under 18.
- Children 18-21 if unmarried and full-time student in post-secondary school.
- Children in elementary school up to age 19.
- Unmarried adult children if disabled before age 22.
- Spouse of worker if child in his/her care receives benefits and is under age 16 or is disabled.
- Spouse age 62 or over (subject to pension offset).
- Dependent children, widows or widowers of deceased entitled or insured workers.

BRIEF LEGISLATIVE HISTORY: Social Security Disability Amendments of 1980 (P.L. 96-265) required a medical review once every three years of SSDI beneficiaries whose disability is not permanent to determine if entitling impairment still exists. These Amendments also changed the relationship between SSDI and Medicare. Prior to these Amendments, unless the entitling criteria was kidney failure, recipients under 65 were required to wait 24 consecutive months of receiving SSDI before being eligible for Medicare, while returning to work resulted in prompt loss of Medicare. Perceiving this as a disincentive to work, Congress changed the requirement to 24 months of SSDI in the space of 5 years to constitute eligibility for Medicare. In addition, the Amendment provided that 36 months of Medicare coverage would be provided after SSDI benefits stopped if the recipient was engaging in SGA but not medically recovered.

In 1982 P.L. 97-455 was enacted in an effort to provide temporary relief to SSDI beneficiaries who are deemed no longer disabled and whose benefits (both SSDI and Medicare) are terminated. The bill authorized continuation of benefit payments and Medicare eligibility until completion of the Administrative Law Judge appeal process. Also authorized under P.L. 97-455 are face-to-face interviews before termination.

1984 SIGNIFICANT AMENDMENTS The Social Security Disability Benefits Reform Act of 1984 made major amendments applying to both SSI and SSDI programs. See Supplementary Security Income Summary for this information.

FEDERAL PROGRAM SUMMARY

NAME OF LEGISLATION: Developmental Disabilities Assistance and Bill of Rights Act of 1978

STATUTORY CITE: 42 U.S.C. 6001

ADMINISTERING FEDERAL AGENCY: Administration on Developmental Disabilities (ADD) of the Office of Human Development Services (HDS) in the Department of Health and Human Services (HHS)

GENERAL AREA OF SERVICE COVERED: Grants to states for providing for the developmentally disabled

MAIN PURPOSE: To assist states in the provision of a comprehensive system of services to insure developmentally disabled persons receive the services necessary to achieve maximum potential as well as services which insure protection of their legal and human rights.

BASIC PROVISIONS: The provisions of the Developmental Disabilities Act fall into four main areas: Basic Support Grants, Protection and Advocacy Grants, Special Project Grants, and University Affiliated Facilities Grants.

Basic support formula grants may be used for state and local planning and administration of services for the developmentally disabled. These grants may also be used for assisting public or private nonprofit agencies which deliver services to the developmentally disabled. Once allotted to the states, these funds are granted for planning and service research activities within certain designated priority areas and may be used to maintain Governor's Planning Councils. Funds for administrative costs in these grants are limited to 5% of the total Basic Support Grant, or $50,000, whichever is less.

Protection and Advocacy Grant funds may be used to help states establish a system to pursue legal as well as other remedies that will assure protection of the rights of developmentally disabled persons. Funds designated for protection and advocacy in these grants are contingent on the existence of a receiving agency independent of a service providing agency. Thus, state protection and advocacy boards were created by this legislation which are entirely separate from state departments that operate developmental disability facilities and/or administer developmental disability services.

State and local governments or other public agencies and nonprofit organizations may access funds through Special Projects Grants. The projects undertaken with grant money should have as their purpose to improve the quality of services to the developmentally disabled, to educate the public regarding developmental disability programs, or to strengthen and assist state developmental disabilities protection and advocacy agencies. Special projects should also be of national significance.

Public or nonprofit facilities associated with a university may be funded under the University Affiliated Facilities portion of the Developmental Disabilities Act. Grant funds under this provision specifically may be used to assist with the cost of administration and operation of facilities for (1) providing interdisciplinary training for personnel concerned with developmental disabilities, (2) demonstrations of the provision of exemplary services related to developmentally disabled and (3) demonstration of findings related to the provision of services.

FUNDING: The Basic Support and Protection and Advocacy Grants to states are determined by federal formulas. The minimum for individual state allotments is now $300,000.

Special Projects and University Affiliated Facilities Grants are applied for and receive directly from the federal administering agency, ADD.

ELIGIBILITY: In order to receive services funded through the Developmental Disabilities Act, an individual must meet the definition of developmentally disabled specified in the Act. That is, an individual must have a condition which is expected to continue indefinitely and which is due to a physical and/or mental impairment manifested before age 22 which results in substantial limitation in at least three of the areas below.

Areas of Functional Limitation:

1. Self-care
2. Receptive or expressive language
3. Learning
4. Mobility
5. Self-direction
6. Capacity for independent living
7. Economic self-sufficiency

Developmentally disabled is further defined by the Act to mean a person who is in need of a combination and sequence of special, interdisciplinary or generic care treatments which are life-long or for an extended duration and are individually planned and coordinated.

BRIEF LEGISLATIVE HISTORY: In 1963, the Mental Retardation Facilities and Construction Act authorized planning activities and construction of facilities for the mentally retarded. In 1970 this act was amended by expanding the target population to include cerebral palsy, epilepsy and other neurological disorders. The 1970 Act also created State Planning Councils to advocate for, plan, monitor and evaluate services for the developmentally disabled. Through the 1970 Act it was emphasized that the purpose of the Developmental Disabilities Program was not to replace existing services, but to strengthen them while planning for and filling in the gaps in the service delivery system.

The 1975 Amendments to the Act removed construction authority from the law and emphasized advocacy by enstating the requirement that states must have a Protection and Advocacy System. These Amendments also added for the first time a section on the rights of the developmentally disabled.

In 1978 the Developmental Disabilities Assistance and Bill of Rights Act was passed. This legislation introduced the idea of priority services and created the new definition of developmentally disabled which emphasized functional deficits rather than clinical definitions. This change in definition meant that many more people could access services designated for the developmentally disabled, including seriously mentally ill who meet the functional definitions and age of onset under the eligibility requirements.

The Omnibus Budget Reconciliation Act of 1981 (OBRA) extended through 1984 the Developmental Disabilities Program by authorizing appropriations for its four sets of grants. This Act also repealed an earlier requirement that specific evaluation systems for developmental disabilities services be in place.

AMENDMENTS OF 1984: In 1984, the President signed into law (October 19, 1984) the Developmental Disabilities Act of 1984 (P.L. 98-527) which continues authorizations for Protection and Advocacy Systems, University Affiliated Facilities (UAF); Special Project Grants; and Federal Assistance for Planning and Service Activities (i.e., the Basic State Grant Program).

Many new features are included in the 1984 Amendments. The new law: restructures the act for better organization of provisions; adds to the purpose statement; requires new reports; allows selection of up to three priority service areas in fiscal year 1987; expands Council membership; establishes a process for redesignation of the Protection and Advocacy system; permits grants to establish and operate UAF satellites; and increases authorization levels for the four program areas in the law.

A new provision restricts, to not more than 25%, the percentage of funds which a designated state administering agency can receive from the state grant to provide services. Another new provision requires employment-related activities as a priority service area once appropriations for the Act exceed $50.25 million.

Council membership is expanded to include representatives of principal state agencies; each UAF or Satellite; Protection and Advocacy (P and A) Systems; local agencies and non-governmental agencies, and private non-profit groups.

The 1984 amendments extend the law through fiscal year 1987.

FEDERAL PROGRAM SUMMARY

NAME OF LEGISLATION: Rehabilitation Act of 1973

STATUTORY CITE: 29 U.S.C. 701

ADMINISTERING FEDERAL AGENCY: Rehabilitation Services Administration (RSA) in the Department of Education

GENERAL AREA OF SERVICE COVERED: Training and placing mentally and physically handicapped persons into remunerative employment.

MAIN PURPOSE: To develop and implement through research, training, services, and the guarantee of equal opportunity, comprehensive and coordinated programs of vocational rehabilitation and independent living.

BASIC PROVISIONS: The Rehabilitation Act established the Rehabilitation Services Administration (RSA) and set up several grant lines for the purpose of providing rehabilitation services to handicapped individuals.

In order to receive federal funds, states must submit a plan to the Commissioner of RSA including the following:

- Designation of a state rehabilitation agency,
- Assurances that each handicapped person will receive services under a written rehabilitation program,
- An agreement to cooperate with other agencies providing services to the handicapped,
- An agreement to conduct studies of the handicapped population, and
- An agreement to provide client assistance in application, etc.

Basic State Grant funds are to be used for covering the costs of providing vocational rehabilitation services to persons with mental and/or physical handicaps. Priority service is focused on needs of those with most severe disabilities. Federal and state funds are used for:

- Diagnosis and comprehensive evaluation,
- Counseling, guidance, referral and placement services,
- Vocational and other training services,
- Physical and mental restoration services,
- Maintenance during rehabilitation period,

- Transportation to secure vocational rehabilitation services,
- Vending stands for handicapped persons,
- Assistance in establishment of rehabilitation facilities, and
- Services to families of individuals receiving vocational rehabilitation services.

Title I of the Rehabilitation Act authorized Innovation and Expansion Grants to states which they could access in order to plan, develop, initiate and expand special services to the most severely handicapped. Title I also authorized American Indian Vocational Rehabilitation Services Grants which were made available to Indian tribal bodies to cover up to 90% of rehabilitation costs.

Title II of the Act established the National Institute of Handicapped Research (NIHR) to administer research grants. Other responsibilities of the NIHR include establishing a network of research centers, disseminating research findings and educational materials, conducting conferences, seminars, workshops and inservice training regarding research and developing statistical report and studies on the demograhics of the handicapped. In 1978 the NIHR was given an expanded mandate and made a separate administrative entity within the Department of Education.

Other discretionary funding lines include construction Grants and Loans for Rehabilitation Facilities and Training Grants. These funds were made available to state agencies, public or nonprofit organizations. Under the loan program, up to 100% of a loan for construction of public or nonprofit rehabilitation facilities is covered.

Grants for Special Programs and Supplementary Services were also created by the Act. These special grants could be tapped by state agencies to assist in the rehabilitation of certain of the most severely handicapped including the establishment of Comprehensive Rehabilitation Centers to serve as focal points in communities for development and delivery of services.

Individual discretionary grant lines were also established in the areas of Employment Opportunities and Comprehensive Independent Living Services. Employment Opportunities grants could be used for three programs: Community Service Employment (up to 90% federally funded), Projects with Industry (up to 80% federally funded), and grants to start up small businesses. The 1978 Amendments to the Act provided for the creation of Centers for Independent Living, Services for Older Blind Individuals, and a Protection and Advocacy system under the initial provision for Comprehensive Independent Living Services. Rehabilitation Service Projects are awarded to state agencies and public nonprofit organizations for projects and demonstrations which hold promise of expanding and otherwise improving services to special groups and solving special vocational rehabilitation problems.

FUNDING: The bulk of the funds authorized under this Act fall into Basic State Grants. The formula used to determine this grant is based on population and weights by per capita income. Grant levels are tied to increases in the CPI. Federal funds must be matched by state funds so that the federal funding makes up no more than 80% of the total state dollars spent in this area. State grant funds are awarded to a state agency designated as the sole state agency to administer the vocational rehabilitation program. State agencies must submit three-year State Plans for vocational services and certify availability of state matching funds. In 1983, $944 million was granted to states to serve 939,000 active cases.

Discretionary grants may be available to state agencies or to other public or nonprofit agencies. They are generally awarded on a competitive basis at a national level. There are, however, exceptions, e.g. grants for inservice training are available to only the state agency while grants for long-term training are available to non-state agency competitors. Also, state agencies must act as a clearing house for applications made to NIHR for research grant money.

The availability of discretionary grant money to both state agencies and other organizations is determined not only by the authorization of such funds, but also by their appropriation. For example, although the legislative authorization for Innovation and Expansion Grants exists, Congress has not appropriated funds for that purpose for several years.

ELIGIBILITY: The mandate of the Rehabilitation Act of 1973 and of its amendments provides services for handicapped individuals. The Act defines the term "handicapped individual" differently for its different objectives. For purposes of defining the handicapped for vocational rehabilitation, the following definition holds. A handicapped individual must:

- Have a physical or mental disability which constitutes or results in substantial handicap to employment, and
- Be reasonably expected to benefit in terms of employability from vocational rehabilitation.

For purposes other than vocational rehabilitation, a handicapped individual is defined as one who:

- Has a physical or mental impairment which substantially limits one or more major life activities,
- Has record of such impairment, and
- Is not impaired due to alcohol or drug abuse.

BRIEF LEGISLATIVE HISTORY: Federal-state vocational rehabilitation programs began with the National Civilian Vocational Rehabilitation Act of 1920 which established a system of state vocational rehabilitation agencies. In 1954, major revisions were made to the Act and it became known as the Vocational Rehabilitation Act. Although the 1954 Act was subject to more than one set of Amendments which made changes such as allowing for more flexible financing and administration of state rehabilitation programs, removing state residency requirements, modifying requirements for state plans, and increasing the federal share of funding to 80%, the next major revision came in 1973 when it was again renamed, this time to be known as the Rehabilitation Act. This last version placed a greater emphasis on providing rehabilitation services to the severely handicapped.

Along with directing states to give priority to the most severely handicapped, the 1973 Act also required states to develop an individualized written rehabilitation program for each client, and it established for the first time by statute the RSA within the Department of Health, Education, and Welfare. (The RSA was later moved to the Department of Education.)

In 1974 a set of Amendments was passed which clarified some of the provisions of the 1973 Act as well as broadened the definition of handicapped for non-vocational rehabilitation purposes and revised the requirement for developing an individualized written rehabilitation plan. The White House Conference on Handicapped Individuals was also established in 1974.

In 1978 the Rehabilitation Comprehensive Services and Developmental Disabilities Amendments made further changes. The formula for determining state allotments was revised and future funding increases were linked to the CPI. The 1978 Amendments also mandated Rehabilitation Research and Training Centers to conduct research and model programs. The National Institute on Handicapped Research was made an independent agency in the Department of Education. Finally, the National Council on the Handicapped was created to review and recommend policies regarding the handicapped.

REHABILITATION ACT AMENDMENTS OF 1984: On February 22, 1984, the Rehabilitation Act Amendments of 1984 were signed (P.L. 98-221). Those amendments are summarized below.

- Extends the state grant portion of the Rehabilitation Act through fiscal year 1986, at a level of $1,037.8 billion in fiscal year 1984 with cost-of-living increases for each of the following years.

- Extends all other programs under the act for three more years.

- Establishes a separate authority for the Helen Keller National Center for Deaf-Blind Youth and Adults.

- Establishes the National Council on the Handicapped as an independent agency within the Federal government. In addition the National Council is charged with the responsibility of reviewing federal programs for handicapped Americans, with a report to Congress and to the President by February 1, 1986.

- Requires the collection of individual client data on age, severity of disability, work status, etc. for the annual report required of the Rehabilitation Services Administration.

- Requires the development of standards by February 1, 1985 for evaluations of existing independent living centers and projects with industry; evaluations to be completed by February 1, 1986.

- Changes the client assistance program from a demonstration, discretionary program to a formula state grant program authorized at $6 million in fiscal year 1984; states must have a client assistance program in place by October 1, 1984, as a condition of eligibility for vocational rehabilitation state grants.

- Provides the Director of the National Institute of Handicapped Research with the authority to test new concepts and innovative ideas, to allow grants to research and training centers to include faculty support for teaching of rehabilitation related courses, and to clarify that research and training centers can include both centers dealing with multiple disabilities and centers focusing on one disability.

- Continues the authorization for the Architectural and Transportation Barriers Compliance Board for three years.

FEDERAL PROGRAM SUMMARY

NAME OF LEGISLATION: The Education of All Handicapped Children Act of 1974 (P.L. 94-142)

STATUTORY CITE: 20 U.S.C. 1411

ADMINISTERING FEDERAL AGENCY: U.S. Department of Education

GENERAL AREA OF SERVICE COVERED: P.L. 94-142 provides for specially designed instruction to meet the unique needs of a handicapped child at no cost to parents or guardians. This special education may include classroom instruction, instruction in physical education, home instruction and instruction in hospitals and institutions. Related services also may be required to assist a handicapped child to benefit from special education, and may include the early identification and assessment of handicapping conditions in children. These related services may be transportation, and developmental, corrective, and other supportive services (including speech pathology and audiology, psychological services, physical and occupational therapy, recreation, and medical and counseling services, except that such medical services shall be for diagnostic and evaluation purposes only).

MAIN PURPOSE: The main objective is to provide all handicapped children with a free and appropriate public education. There are four major purposes of this law. First, it guarantees the availability of special education programming to handicapped children and youth who require it. Second, it assures fairness and appropriateness in decision making about providing special education to handicapped children and youth. Third, it establishes clear management and auditing requirements and procedures regarding special education at all levels of government. Fourth, it financially assists the efforts of state and local government through use of federal funds.

BASIC PROVISIONS: "Appropriate" education receives its definition for each child through the mechanism of the individualized written education program (IEP) as required by P.L. 94-142. Therefore, what is agreed by all parties becomes, in fact, the "appropriate" educational program for each particular child. An IEP is a written state for each handicapped child developed in any meeting by a representative of the local education agency or an intermediate educational unit who shall be qualified to provide, or supervise the provision of, specifically designed instruction to meet the unique needs of handicapped children.

Nine critical stipulations must be adhered to by both the state and its local intermediate educational agencies. These are:

- A free, appropriate public education for all handicapped children must be provided.

- An individualized education program should be maintained for all handicapped children.
- Due process procedures should be guaranteed.
- Regular parent or guardian consultations must be held.
- Special education will be provided to all handicapped children in the "least restrictive" environment.
- Nondiscriminatory testing and evaluation will be assured.
- Policies and procedures must protect the confidentiality of data and information.
- This free and appropriate public education will be provided at no cost to parents or guardians.
- A surrogate to act on behalf of child will be appointed when the parents or guardians are either unknown or unavailable or when such child is a legal ward of the state.

On December 2, 1983, The Education of the Handicapped Act Amendments was signed into law. P.L. 98-199 revises and reauthorizes the state grant and ten discretionary programs provided under the existing Education of the Handicapped Act. Also, P.L. 98-199 contains modest increases in the authorization levels for existing EHA programs. Since the state grant program is a permanent authority, it does not have to be reauthorized periodically. Congress does have an obligation to set a yearly spending ceiling for the state grants. P.L. 98-199 sets the FY 84 level at $1.07 billion. Some of the major features of the new legislation are:

- Expands the pre-school incentive grant authority to make early intervention services accessible to children from birth to age five.
- Offers early education growth for specialized educational and related services for developmentally delayed children age 5 and younger.
- Supports research and demonstration projects aimed at helping handicapped youth develop personal and job related skills.
- Earmarks certain funds to instruct parents of handicapped youngsters in how they may access the political system to advance the welfare of their children.
- Mandates a special study on the number and condition of handicapped children and youth in schools who have serious emotional problems.

- Reduces the role deaf-blind centers play in providing direct services.

- Identifies the Office of Special Education Programs as the organizational unit within the Department of Education's Office of Special Education and Rehabilitative Services.

- Allows the Secretary to bypass the state educational agencies in providing special educational services to handicapped children attending private schools.

FUNDING: Funding for P.L. 94-142 comes from both federal and state sources. Basic state grant dollars are awarded to states on a formula basis to assist in providing a free and appropriate public education and related services to all handicapped children. The basic state grant program was funded federally at $1.08 billion in 1984.

Special purpose federal funds are also awarded for deaf-blind centers, severely handicapped projects, secondary and transitional services, postsecondary programs, innovation and development, and media services and captioned films. Other federal special project funds include regional resource centers, recruitment and information, special education personnel development and special studies on program effectiveness.

In 1984 $32 million was appropriated federally for preschool incentive grants awarded to states based on the number of handicapped children aged 3 through 5 served. Funds may be used for services to eligible children from birth to five years.

Federal funding in 1984 for Education for the Handicapped including basic state grants, pre-school incentives and special project monies was $1.259 billion.

In order to receive funds under this law, states are required to submit an acceptable state plan including individualized program planning, procedural safeguards for handicapped children, and personnel training for special education programs.

Also, numerous other public agencies can and do assist in paying for related services. Some examples of other legislation providing funding to handicapped children include Title I of the federal Elementary and Secondary Education Act and programs authorized by the older Education of the Handicapped Act.

ELIGIBILITY: P.L. 94-142 applies to all handicapped children who require special education and related services, ages 3 to 21 inclusive. Handicapped children are defined in the Act as mentally retarded, hard of hearing, deaf, orthopedically impaired, other health imparied, speech impaired, visually handicapped, seriously emotionally disturbed, or children with specific learning disabilities who, by reason thereof, require special education and related services.

This definition establishes a two-pronged criteria for determining child eligibility under the Act. The first is whether the child actually has one or more of the disabilities listed in the above definition. The second is whether the child requires special education and related services. Not all children who have a disability require special education; many are able to and should attend school without any program modification.

The state may count all handicapped children served between the ages of three to twenty-one inclusive. However, the total counted may not be a number greater than that number which equals twelve percent of the school age population aged five to seventeen. For the children in the 3-5 and 18-21 age range, however, this mandate does not apply if the requirement is inconsistent with state law or practice, or any court decree.

BRIEF LEGISLATIVE HISTORY: As previously mentioned, P.L. 94-142 was amended by P.L. 98-199 in 1983. The basic provision of the EHA Amendments are stated in the above "Basic provisions of bill and funding" section.

FEDERAL PROGRAM SUMMARY

NAME OF LEGISLATION: Vocational Education Act of 1963

STATUTORY CITE: 20 U.S.C. 2301

ADMINISTERING FEDERAL AGENCY: U.S. Department of Education

GENERAL AREA OF SERVICE COVERED: Vocational education programs

MAIN PURPOSE: To assist states in improving planning and conducting vocational programs at the state and local level for persons of all ages who desire and need education and training for employment.

BASIC PROVISIONS: There are three parts to the Vocational Education Act. Part A authorizes grants to states to expand and improve vocational education programs. This is the basic source of federal support under the Act. Part B authorizes grants for special projects. Part C defines terms in the Act.

There are two major programs provided under Part A. The largest program provides basic grants to state boards of education for the purpose of providing activities which may include:

- Basic vocational education programs
- Cooperative vocational education programs
- Work study programs
- Energy education
- Construction of area vocational facilities
- Provision of stipends
- Placement services for students who have successfully completed vocational education programs
- Industrial arts programs
- Programs for special groups, including support services for women entering certain occupations; day care for children of vocational students; and displaced homemakers
- Construction and operation of residential vocational education facilities

- Vocational training through arrangements with private vocational training institutions
- State and local administrative costs

Eligible recipients for subgrants from the state to provide vocational education are local educational agencies and post secondary institutions. Ten percent of these grant funds must be used for vocational education for the handicapped. Other designated percentages of state allotments must go to the disadvantaged and to postsecondary and adult vocational education.

The second program provided for under Part A authorizes grants for consumer and homemaking education programs. These grants can also be used for outreach activities for youth and adults including the handicapped as well as related services including teacher training and supervision, curriculum development, research, program evaluation, and special demonstration projects.

Part B authorizes grants for vocational education program improvement projects of national significance. These projects may be used for research, curriculum development, demonstration projects, and also for the operation of a National Center for Research in Vocational Education.

FUNDING: Basic state grants under the act are provided according to formulas which relate to state per capita incomes. Grants under Part B are not allocated by formula, but may be applied for by public and private organizations and agencies.

ELIGIBILITY: Vocational education programs provided for by this Act must be made available to all students served by state boards of education. Ten percent of formula grant money is designated set-aside for the purpose of serving handicapped persons. Part C of the Act defines handicapped persons as "persons who are mentally retarded, hard of hearing, deaf, speech impaired, visually handicapped, seriously emotionally disturbed, crippled, or other health impaired persons who by reason thereof require special education and related services, and who because of their handicapping condition, cannot succeed in the regular vocational education programs without special education assistance or who require a modified vocational education program."

BRIEF LEGISLATIVE HISTORY: Federal support for vocational education began in 1917 with the Smith-Hughes Act, but the passing of the Vocational Education Act of 1963 marked the creation of the first permanent authority to assist states in supporting vocational training for youth and adults through public schools. The 1963 Act also provided for construction of area vocational schools, work-study programs, and demonstration projects.

In 1968, amendments to the Act increased the flexibility with which states could use formula grant funds and established the 10% allotment for handicapped persons. The Education Amendments of 1976 continued this 10% requirement and further required states to match federal handicapped fund by 50% and to use set-aside funds in ways consistent with each state's Education of the Handicapped Plan under P.L. 94-142.

AMENDMENTS OF 1984: In 1984, the 98th Congress extended vocational education programs for five years by passing amendments to the Vocational Education Act (P. L. 98-524). These amendments include provisions guaranteeing that students with disabilities will receive vocational education services developed specifically to meet their individual needs.

In the 1984 amendments, the basic state grant program maintains the 10% set-aside for handicapped students, but distributes the funds for each fiscal year based on numbers of handicapped and economically disadvantaged served the previous year.

The 1984 law also provides criteria for serving handicapped students. They must have: (1) equal access to recruitment, enrollment, and placement in vocational education; (2) the full range of vocational education services offered to non-disabled students; (3) vocational education services offered in the least restrictive environment and included in the Individual Education Plan (IEP).

Another important provision passed in 1984 allows federal funds to be used for excess costs of educating a disabled student in a regular classroom. This gives financial incentive for providing vocational education to disabled in regular classes.

A further amendment requires a state to have a State Council on Vocational Education to oversee implementation of the 1984 act and to advise on the content of the state plan. Other special programs are established under P. L. 98-524, including industry-education partnerships in training for high technology occupations and assistance targeted at programs for severely economically and educationally disadvantaged.

FEDERAL PROGRAM SUMMARY

NAME OF LEGISLATION: Elementary and Secondary Education Act of 1965

STATUTORY CITE: 20 U.S.C. 241

ADMINISTERING FEDERAL AGENCY: Department of Education

GENERAL AREA OF SERVICE COVERED: All aspects of elementary and secondary education

MAIN PURPOSE: To provide for the improvement of elementary and secondary education throughout the country especially for the educationally disadvantaged including the handicapped.

BASIC PROVISIONS: The Elementary and Secondary Education Act (ESEA) constitutes the primary source of federal aid to public school systems. Through its ten titles virtually all aspects of elementary and secondary education are addressed. Titles I and IV, however, are most relevant to handicapped children.

Title I of ESEA authorized federal aid for supplementary educational services to children from low-income families who are considered educationally deprived, including handicapped. This multi-billion dollar program made federal funds available to 90% of all school districts. Under Title I, grants are also available to states to provide comprehensive educational programs for handicapped children in state operated and supported schools.

Title IV of ESEA addresses improvement in local educational practices. Grants under this title may be used for development and demonstration of activities in areas of serious educational problems including children with special needs, i.e., deprived, gifted, talented and handicapped. Projects are also encouraged in areas with high concentrations of low-income families and to develop innovations in compensatory education.

FUNDING: Title I grants for handicapped are determined by formula. The state allocation is determined by multiplying the number of handicapped children under 21 by 40% of the state's average per capita expenditure for public elementary and secondary schools or by the national average per pupil expenditure, whichever is higher. Fifteen per cent of Title IV grants must be used for special programs or projects for the education of handicapped children.

ELIGIBILITY: Funds which are earmarked for handicapped children under ESEA must go for services to children who are mentally retarded, hard of hearing, deaf, speech impaired, visually handicapped, seriously emotionally disturbed, orthopedically handicapped, subject to other health impairments, deaf-blind, or who have a specific learning disability.

BRIEF LEGISLATIVE HISTORY: ESEA represented the first major federal legislative commitment to improving elementary and secondary education. P.L. 89-313, which passed later in the same year, amended Title I of ESEA by making aid possible to state agencies operating or supporting schools for the handicapped by formula. This has been an important resource for states in serving youth in state institutions.

The primary aim of P.L. 89-313, was to assure that all handicapped children had available to them a free, appropriate public education which emphasizes special education and related services designed to meet their unique needs. P.L. 89-313 also established the Bureau of Education for the Handicapped (BEH) in the Office of Education. BEH assumed all fiscal authority for P.L. 89-313 except the annual determination of Title I funds that are allocated to the states. In 1975, P.L. 89-313 was amended by P.L. 93-380 which made it possible for funds going to handicapped children institutions to follow these children to local education agencies (LEAs, i.e., local public schools) upon deinstitutionalization. In 1967 full funding for state operated and supported schools for the handicapped was established by amendment. In FY 1983, under P.L. 89-313, $146.5 million was granted to states for comprehensive educational programs for handicapped children in state operated or state supported schools.

The Education Amendments of 1974 decreased the per capita federal level from 50% to 40% of the average per pupil costs and restricted local school agencies from receiving less than 80% or more than 120% of the national average. These changes were intended to equalize federal aid per capita among states and local school districts.

FEDERAL PROGRAM SUMMARY

NAME OF LEGISLATION: The Older Americans Act of 1965

STATUTORY CITE: 42 U.S.C. 3001

ADMINISTERING FEDERAL AGENCY: Administration on Aging, Department of Health and Human Services (HHS)

GENERAL AREA OF SERVICE COVERED: Social Services to the elderly

MAIN PURPOSE: Develop programs for assisting older persons to meet their economic, health and personal needs

BASIC PROVISIONS: The Older Americans Act of 1965 establishes the Administration on Aging (AoA) which is responsible for a variety of programs and activities serving older persons. A primary function of the (AoA) is to administer grants to state Offices on Aging to support services to the elderly at the community level.

In order to receive federal funds a states' Office on Aging must provide advocacy services on behalf of its elderly population, must analyze the needs of older persons within the state, must divide the state into planning and service areas and designate Area Agencies on Aging (AAA) to coordinate services for the elderly within this area.

In order to receive funds from the state Office on Aging, the Area Agency on Aging must develop a comprehensive and coordinated system of services within their area for older persons, generate new resources for services and allocate funds to service providers to deliver the following services:

Supportive Services, including transportation; homemaker and home health services; information and referral; residential; legal and other counseling services

Nutritional Services, including congregate meal programs; meals to the homebound elderly

The Act also authorizes a program of discretionary grants and contracts to support training, technical assistance, education and research projects.

FUNDING: Grants are provided to states according to a formula which takes into account the size of the elderly population within the state.

Title III, Parts A and B - Grants for Supportive Services and Senior Centers are to provide assistance to State and area agencies for support of programs for older persons via statewide planning and provision of social services including multi-purpose senior centers. A state plan covering two, three, or four years with annual updates must be submitted and approved by Commissioner on Aging.

Programs are funded on federal/state matching basis. In 1983, $241 million was appropriated federally for supportive services and senior centers. An additional $21.7 million was federally designated for state agency administration.

Title III, Part C - Grants for Nutrition Services supply older Americans with low cost meals, nutrition education, and meals served in congregate settings or delivered to the home.

States receive these funds on a formula basis including population over 60 years. The nutrition portion of this program requires a federal/state matching basis at a ratio of 85-15. In 1983 federal grants for Congregate Nutrition Services were $319 millions while Home Delivered Nutrition Services received $62 million. Awards to states are non-competitive based on approval of State Plan.

ELIGIBILITY: The mandate of the Older Americans Act is to provide services to those individuals over 60 years of age.

BRIEF LEGISLATIVE HISTORY: The Older Americans Act of 1965 established the Administration on Aging (AoA) which was responsible for a number of programs and activities serving the elderly. The Act also established grants to state agencies to support services to the elderly at the community level.

Since 1965 the Act has been amended ten times. The most significant changes occurred in 1972, when a national nutrition program for the elderly was established to provide funds for congregate meal programs and meals to the homebound elderly. In 1973 the Act was amended again requiring state Office on Aging to divide their states into planning areas and designate an Area Agency on Aging to coordinate and monitor the services to the elderly within that area. This amendment also provided grants to states to implement model projects and develop senior centers.

The Act was amended again in 1978 collapsing the legislation establishing the nutrition program, the grants for senior centers and social services into one Title. These amendments also strengthened the area agencies on aging and the states Office on Aging advocacy function and provided grants to Indian tribes for nutritional services to their elderly.

The Act was amended in 1981 allowing the state and the area agencies greater administrative flexibility and planning by decreasing the federal requirements that states and individual areas had to meet in order to receive funds.

In 1984, the Older Americans Act was amended and reauthorized for the next three years. Increases in funding authorizations and new program emphasis were identified.

The major authorization increases are in Title III home support and nutrition programs. Also, the transfer authority of the state, which shifts money among Title III programs, would gradually be increased from 25 percent in 1985 to 30 percent in 1987. The limit was 20 percent in 1984.

A new emphasis is being placed on targeting programs to "older individuals with the greatest economic or social needs." The Administration on Aging is now required to consult with organizations representing minorities in providing training and technical assistance to state and area agencies. Area agencies will also be required to include minority individuals on advisory councils.

For the first time, funding for families of Alzheimer's disease victims will be made a "priority" under the Title III supportive services grant program. Grants for elder abuse will not be given a priority status, but they have been retained as a permissive service under Title III.

FEDERAL PROGRAM SUMMARY

NAME OF LEGISLATION: The Food Stamp Act of 1977

STATUTORY CITE: 7 U.S.C. 2011

ADMINISTERING FEDERAL AGENCY: The Food and Nutrition Service of The United States Department of Agriculture

GENERAL AREA OF SERVICE COVERED: Nutritional assistance to the needy

MAIN PURPOSE: To improve diets of low income households by supplementing their food purchasing ability.

BASIC PROVISIONS: The Food Stamp Act provides benefits to eligible individuals in the form of stamps or coupons which can be used to buy certain foods in authorized retail stores. Eligible households receive a free coupon allotment in an amount which varies according to household size and net income. All fifty states must participate in the program.

Food coupons may be used to purchase plants and seeds for use in home gardens to produce food for personal consumption. In addition, food coupons may be used by eligible elderly and handicapped persons (and their spouses), who cannot prepare their own meals, to purchase meals prepared and delivered by authorized meal delivery services. Food coupons also may be used to purchase food on behalf of SSI or SSDI recipients who reside in small, community-based living arrangements, which house no more than 16 persons.

FUNDING: The Food Stamp program is financed through federal general revenue funds. The federal government finances 50% of all administrative costs of the program. The remaining 50% of the administrative costs are borne by the states and localities.

Each state must submit a plan of operation on how the Food Stamp Program will be conducted in every political subdivision of the state. In 1983 federal food stamp payments to individuals was $11.2 billion with an average monthly participation of 21.7 million persons.

ELIGIBILITY: Participants in the Food Stamp program have eligibility determined by state or local welfare offices, based on national eligibility standards which take into account family size, income and level of resources. To be eligible for food stamps a household's income will have to be at or below a certain percent of the poverty level (currently 130% of the poverty level). There are work registration and job search requirements for adult persons who receive food stamps unless they are exempted for reasons of health or child care responsibility. Drug addicts and alcoholics in approved rehabilitation programs may use food coupons to purchase meals prepared under the program. Elderly persons and spouses may use food coupons to purchase meals through communal dining or authorized meal delivery.

BRIEF LEGISLATIVE HISTORY: The first federal food stamp program was established in 1939. The major purpose of the program was feeding poor families while simultaneously stabilizing food prices by removing surplus agricultural commodities from the market to use for the program. This program ended in 1945. In 1961, a food stamp pilot project was initiated which was similar to the 1939 program. The project ran for two years in a few selected needy areas of the country. Based on the findings of this project and on reports of wide-spread hunger, Congress enacted the Food Stamp Act of 1964.

Under this Act, states administered the program and determined eligibility according to Congressional intent - "that any household should be eligible whose income is determined to be a substantially limiting factor in the attainment of a nutritionally adequate diet." After a household made an application to participate in the program, the state agency responsible for administering the program reviewed the household's food budget. If appropriate, this agency would then set a more adequate food budget for this household. Food stamps could then be purchased at a discounted rate by this household and were redeemed at a greater monetary value when a household presented the coupons at the time of purchase. This legislation also provided two year authorization for the program. State participation in the program was optional.

In 1967, Congress amended the Act which extended the program for two more years. These amendments also set ceilings on the appropriations level for the program. The Act was amended again in 1969 to provide a one year extension of the program.

Between 1970-77, the Food Stamp Act was amended twice. The 1970 amendments extended the program for three years, increased the appropriation ceiling for FFY 71, left appropriations open-ended for FFY 72 and 73, provided free food stamps to those households with an income under $300 a month and imposed a work requirement on all participants.

The 1973 amendments extended the food stamp program again, imposed statutory spending ceilings and mandated that all areas of the country participate in the program.

The Food Stamp Act of 1977 which amended the 1964 Act increased the programs statutory spending ceiling, broadened eligibility to include individuals participating in alcohol or drug abuse treatment centers, established national eligibility standards, and authorized the Department of Agriculture to conduct pilot projects including a test for cashing out food stamps, i.e., paying households the value of food stamps in cash rather than in coupons.

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The 1979 amendments to this program increased the statutory spending ceiling and extended the program for two more years. The provisions in these amendments also authorized food stamps for blind and disabled persons and for residents of community living arrangements by redefining eligible households to include:

> Disabled or blind recipients of benefits under Title II (SSDI) or Title XVI (SSI) of the Social Security Act who are residents in a public or private nonprofit group living arrangement that is certified by the appropriate state agency or agencies under regulations issued under Section 1616(e) of the Social Security Act, which serves no more than 16 residents.

These amendments also changed the definition of the term food to include meals served in small group living arrangements.

Provisions in the Omnibus Budget Reconciliation Act of 1981 also had a significant impact on The Food Stamp Program. One provision lowered the appropriation ceiling for the program. Another tightened the eligibility standards requiring households to be at or below 130% of the poverty level.

Authority to continue the Food Stamp Program has been extended through September 30, 1985.

FEDERAL PROGRAM SUMMARY

NAME OF LEGISLATION: The Job Training Partnership Act (JTPA)

STATUTORY CITE: 29 U.S.C. 1732

ADMINISTERING FEDERAL AGENCY: U.S. Department of Labor

GENERAL AREA OF SERVICE COVERED: Job training for the disadvantaged

MAIN PURPOSE: To establish programs to prepare youth and unskilled adults for entry into the labor force and to provide job training to economically disadvantaged and other individuals

BASIC PROVISIONS: There are five titles within JPTA. Title I establishes the administrative structure for the delivery of job training services. Title II provides block grants to the states for these training services and an array of related activities. Title III provides monies to the states to assist displaced workers in obtaining new jobs. Title IV establishes a federally administered program to provide employment and training programs for native Americans, migrant and seasonal farm workers and veterans. Title IV also re-establishes the national Job Corps. Title V amends the Wagner-Peyser Act which establishes the Job Service Program. This provision also amends Title IV of the Social Security Act relating to the Work Incentive Program (WIN).

Title I delineates the administrative structure a state must establish in order to receive federal funds for this program. The governor of a state must first divide the state into service delivery areas (SDA) to promote the effective delivery of job training services. Each SDA is required to establish a Private Industry Council (PIC) consisting of representatives from area business and industry, educational agencies, organized labor, rehabilitation agencies, community organizations and the local public employment service. The PIC in each SDA is responsible for providing policy guidance for, reviewing, monitoring and evaluating the job training plan for its SDA. The PIC is also responsible for selecting grant recipients and entities that will administer the job training plan.

In order for an SDA to receive funds from the state, a job training plan must be developed. The plan identifies the entities which will administer the program, describes the services to be provided, delineates eligibility standards and establishes performance goals for each service delivering entity. The administering agency, with the assistance of the PIC, is responsible for allocating grants to individual service providing entities.

Title I also provides financial assistance to the states for developing a state labor market information systems program.

Title II of JPTA authorizes monies for block grants to states for the purpose of providing the following services:

- Job search assistance
- Job counseling
- Remedial education and basic skills training
- Institutional skills training
- On-the-job training
- Outreach to make individuals aware of the use of employment and training programs
- Programs to develop work habits to help them obtain and maintain employment
- Supportive services necessary to enable individuals to participate in the program and assist them in retaining employment
- Education to work transition activities
- Literacy training and bilingual training
- Vocational exploration
- Attainment of certificates of high school equivalency
- Job development
- Pre-apprenticeship programs
- Disseminating information on program activities to employers
- On-site industry-specific training programs

This title also contains a separate authorization for a summer youth program. Under this program grants are made to the states in the spring of each year to subsidize minimum-wage public sector jobs for youths between 14 and 21 during the summer months.

Title III authorized monies to the states for training and employment programs to assist displaced workers locate new jobs.

Title IV establishes a federally administered program to provide employment and training services for Native Americans, migrant and seasonal farm workers. It also maintains the national Jobs Corps for economically disadvantaged youth and establishes employment programs for veterans.

Each state identifies the eligible population for the displaced workers program. These persons include but are not limited to those who have been terminated/laid off from employment and have received or are receiving unemployment compensation and are unlikely to return to their previous occupation.

Title IV delineates the eligibility requirements for enrollees in the Job Corps. To participate in this program an individual must be between 14 and 21 and must be economically disadvantaged (as defined under Title II) or is currently living in an environment characterized by cultural deprivation, a disruptive home life or any other disorienting condition. The age limitation for the enrollee may be waived in the case of a disabled individual if he/she is economically disadvantaged.

Title IV authorizes monies for employment programs for service-connected disabled veterans, includes veterans of the Vietnam era and veterans recently separated from military service as eligible program participants.

STATE AND SDA REQUIREMENTS: No more than 15% of Title II funds may be used for an SDA's administrative costs and no more than 30% may be used by the state for their administrative costs. The governor is required to prepare a statement of goals and objectives for job training and placement within the state. The governor is also required to establish a state Job Coordinating Council composed of representatives from business and industry, state legislators, state vocational education organizations, representatives of local governments and representatives of the general population. This council is responsible for recommending the Governors plan; reviewing the programs conducted in the states SDA; identifying employment needs throughout the state and reviewing plans of all state agencies providing services under this act.

No funds are to be used for wages, allowances, or stipends.

No funds are to be used to assist in relocating establishment if it results in increasing the unemployment rate in the original area.

No person or organization may charge an individual for referral to a training or education program.

The governor of a state must allocate 78% of Title II funds to individual SDAs according to a formula which takes into account the unemployment level of each SDA and the number of economically disadvantaged individuals in a particular SDA. Of the remaining 22% of these funds, 8% must be used to provide financial assistance to state education agencies which provide training under this act, 3% must be used to provide training programs for older persons, 6% must be used to provide incentive grants for programs exceeding performance standards, including incentives for serving the hard-to-place individuals and 5% will be used for auditing activities.

Finally no less than 40% (of the 78%) of Title II funds must be available for those services to individuals between the ages of 16 and 21.

BRIEF LEGISLATIVE HISTORY: The Job Training Partnership Act was signed into law in October of 1982 to replace the Comprehensive Employment and Training Act (CETA).

CETA, which was originally enacted in 1963, authorized monies to assist economically disadvantaged, unemployed and underemployed persons obtain the necessary job skills and locate employment. From 1963 until 1978 the Act was amended several times to include provisions for the disabled.

The 1973 amendment authorized formula grants to state and local entities to administer comprehensive employment and training services which included transitional public service employment aimed at enhancing workers opportunity to seek employment in the private sector. These amendments also include monies for research and demonstration grants to assist unemployed persons, who have serious problems in the labor market, acquire the skills necessary to hold a job.

The 1978 amendments gave specific recognition to the employment and training needs of the disabled. Among these provisions were requirements that an entity participating in the CETA program include, in their annual plan, descriptions of services to the disabled. This amendment also increased the mechanisms for input of the disabled into local and state plans, prohibited CETA entities from discriminating on the basis of being disabled and required CETA entities to make efforts to remove architectural barriers to employment of the disabled. A new section was added to the Act by these amendments which established programs to train persons working with the disabled and authorized project grants to provide job training and related services for disabled individuals.

FEDERAL PROGRAM SUMMARY

NAME OF LEGISLATION: Various Acts Related To The Administration of Veterans Benefits

STATUTORY CITE: 38 U.S.C.

ADMINISTERING FEDERAL AGENCY: Veterans Administration

GENERAL AREA OF SERVICE COVERED: Comprehensive benefits and programs for veterans, their widows, and their dependents

MAIN PURPOSE: To provide assistance to United States veterans, their widows, and their dependents

BASIC PROVISIONS: The Veterans Administration (VA) provides a most comprehensive system of assistance and care for veterans. In 1985 the VA expects to provide benefits and service to the country's 28.2 million veterans, the 51.7 million members of their families, and the 2.4 million survivors of deceased veterans. Potential recipients of VA benefits are estimated at 82.3 million, or 35% of the total population of the United States. The VA requested a $27.2 billion budget to carry out its function in FY 1985, a $993 million increase from FY 1984.

VA programs are funded through 17 appropriations, 10 revolving funds, an intragovernmental fund and 5 trust funds. However, for a general overview, the VA budget can be broken down in the following manner.

Benefits programs, including:

- Compensation
- Pensions
- Burial benefits and miscellaneous assistance
- Readjustment benefits
- Veterans insurance and indemnities
- Reinstated entitlement program for survivors
- Emergency veterans job training

Totaling $15,141,700,000 or 58.7% of the total VA budget.

Medical programs, including:

- Medical care
- Medical and prosthetic research
- Medical administration and miscellaneous operating expenses
- Grants for construction of State extended care facilities
- Grants to the Republic of the Philippines

Totaling $9,068,143,000, or 35.2% of the total VA budget.

Construction programs, including:

- Construction, major projects
- Construction, minor projects

Totaling $821,794,000, or 3.2% of the total VA budget.

General operating expenses and miscellaneous, including:

- General operation expenses
- Grants for the construction of State veterans cemetaries

Totaling $760,454,000, or 2.9% of the total VA budget

Medical Care in the VA

Of special importance in both research in mental illness and provision of a wide array of mental health services is the extensive veterans health care system. In 1983 total medical care VA outlays were $8.3 billion. The VA conducts most of this research and care at its 172 hospital centers, 226 outpatient clinics and 101 nursing home units. Much of the long-term care is provided under contract in community nursing homes or subsidized state veterans' homes. Veterans with service-connected disabilities receive priority care, but about 70% of VA hospital patients have no service-connected conditions.

VA hospital bed capacity in 1982 was 80,000. Thirty percent of these beds are for psychiatric care and 30% more are used for extended care. Fastest growing expenditures are for nursing homes and outpatient care. The VA has under its care about 7% of the nation's hospitalized patients.

Many benefits in a variety of areas are available to veterans through the VA and are summarized below. These large number of benefits can assist veterans in securing a wide continuum of mental health services under the vertically-integrated Veterans Administration system. A comprehensive set of cash benefits can assist with maintaining a person with mental disabilities as well as the use of extensive inpatient, nursing home and outpatient services in the VA itself.

The VA administers a myriad of programs and benefits for veterans and their dependents and survivors. The following descriptions of selected benefits represent only a small minority of the range of benefits and services available.

COMPENSATION: Compensation is available to all veterans with service-connected disabilities, that is, disabilities that are the result of injury or disease incurred or aggravated during active service, in the line of duty during wartime or peacetime service by a veterans who was discharged or separated under other than dishonorable conditions. The amount of compensation paid is not based on financial need or on pay grade, but on severity of disability. Compensation may be paid to widows, children, and parents if the veteran is deceased.

PENSIONS: Pensions are provided to needy veterans with wartime service of 90 days or more who are permanently and totally disabled from reasons not traceable to service, nor due to wilful misconduct. Veterans 65 years of age or older and not working are considered permanently and totally disabled. The amount paid for pensions is based on annual income, those with the lowest income receiving the highest pension. Needy survivors of deceased eligible veterans are also eligible for pension benefits.

HOSPITALIZATION: All veterans who were discharged or released from active service under conditions other than dishonorable are eligible for hospitalization according to the following admission priorities.

First - Veterans needing hospitalization because of injuries or disease incurred or aggravated in the line of duty in active service.

Second - Veterans who were discharged or retired due to a disability or are not receiving compensation who need treatment for some ailment not connected with their service, will be admitted as beds are available.

Third - Veterans who were discharged or retired for disability or are not receiving compensation, and who apply for treatment of a nonservice-connected disability may be admitted to a VA hospital (1) if hospitalization is necessary, (2) if they are unable to pay hospital charges (unless they are 65 or older) and (3) if beds are available.

NURSING HOME CARE: Intermediate nursing care and related medical care in VA Nursing Home Care Units may be provided to veterans according to the priorities for hospitalization. Private nursing home care may be paid for by the VA for (1) veterans who require nursing care for a service-connected disability after medical determination by the VA and (2) any person in an Armed Forces hospital who requires a protracted period of nursing care and who will become a veteran upon discharge from service. Normally, VA authorized care may not be provided for more than six months except for veterans whose hospitalization was primarily for a service-connected disability.

MEDICAL CARE FOR DEPENDENTS OR SURVIVORS: The Civilian Health and Medical Program of the Veterans Administration (CHAMPVA) is a medical benefits program through which the VA helps pay for medical services obtained from civilian sources by eligible dependents and survivors of certain veterans. The following persons are eligible for CHAMPVA provided they are not eligible for CHAMPUS or Medicare:

- The spouse or child of a veteran who has a total and permanent disability which is service-connected.

- The surviving spouse or child of a veteran who died from a service-connected disability.
- The surviving spouse or child of a person who died while in active duty.

ALCOHOL AND DRUG DEPENDENTS: Veterans who left service under other than dishonorable conditions may receive treatment for alcohol or drug dependence. After hospitalization for alcohol or drug treatment, veterans may be eligible for outpatient care, or may be authorized to continue treatment or rehabilitation in facilities such as halfway houses, therapeutic communities, or mental health centers at VA expense.

OUTPATIENT MEDICAL TREATMENT: Outpatient medical treatment includes medical examinations and related medical services including rehabilitation, consultation, professional counseling training and mental health services as necessary in connection with treatment of physical and mental disabilities. As a part of the medical treatment, veterans may be eligible for home health services necessary or appropriate for the effective and economical treatment of disabilities, including such home improvements and structural alterations as are determined necessary to assure the continuation of treatment or to provide access to the home or to essential sanitary facilities. The following persons are eligible for outpatient care.

- Any veteran, for a service-connected disability.
- Any veteran discharged or released from the active military, naval or air service for a disability incurred in the line of duty, for that disability.
- Any veteran with a service-connected disability rated at 50% or more, for any medical condition.
- Any veteran of World War I or the Mexican Border period, any veteran in receipt of aid and attendance or housebound benefits, or any former POW for any medical condition.
- Certain disabled veterans participating in a rehabilitation program.
- Any veteran eligible for hospitalization, for medical services on an ambulatory care basis when such services are reasonably necessary in preparation for hospital admission or to make the need for hospital admission unnecessary.
- Any veteran who has been granted hospital care, medical services reasonably necessary to complete treatment incident to such hospital care.

- Commonwealth army veterans and new Philippine scouts for service-connected disabilities.

EDUCATIONAL ASSISTANCE: The VA administers two basic programs for veterans and servicepersons seeking assistance for education or training. For eligible persons with service between February 1, 1955 and December 31, 1976, such assistance is available under the GI Bill. Veterans and servicepersons who entered the military on or after January 1, 1977 may receive educational assistance under a contributory plan. Under the GI Bill, educational training may be received by veterans who served on active duty for more than 180 continuous days, any part of which occurred after January 31, 1955, but before January 1, 1977, and who were released under conditions other than dishonorable, or continue on active duty, are eligible under the Veterans Readjustment Benefits Act of 1966, as amended. Those who served during the same period, but for 180 days or less, and were discharged for a service-connected disability also are eligible. Individuals who contracted with the Armed Forces and were enlisted in or assigned to a reserve unit prior to January 1, 1977, and who as a result of this enlistment or assignment, served on active duty for more than 180 days, any part of which began within 12 months after January 1, 1977 and who were discharged from active duty under conditions other than dishonorable also are eligible. Time limits on duration of eligibility exist according to duration of service.

In general, an educational institution approved for training may include any public or private elementary, high, vocational, correspondence, or business school, junior or teachers college, normal school, college or university, professional, scientific or technical institution, or any other institution which furnishes education at the secondary school level or above.

Veterans who served and servicepersons currently serving are eligible if they (a) entered active duty after December 31, 1976, and (b) were released under conditions other than dishonorable or continue on active duty but have completed their obligated period of service (or six years of active duty whichever comes first), and (c) have satisfactorily contributed to the program. Satisfactory contribution consists of the monthly deduction of $25 to $100 from military pay, up to a maximum of $2,700, for deposit in the special training fund. Participants, while on active duty, may make a lump sum contribution to the fund. The contributory plan permits the serviceperson to voluntarily participate in a plan for future education or training in which the participant's savings are administered and augmented by the Government at a rate of $2 per every $1 contributed by the serviceperson.

VOCATIONAL REHABILITATION: Veterans who served during World War II or thereafter are eligible for vocational rehabilitation if all three of the following conditions are met:

- They suffered a service-connected disability in active service which entitles them to compensation, or would do so but for receipt of retirement pay.
- They were discharged or released under other than dishonorable conditions.
- The VA determines that they need vocational rehabilitation to overcome the handicap to employment caused by their disabilities.

Generally, the veteran must complete a rehabilitation program within the 12-year period from the date of notification of entitlement to VA compensation. This period may be extended if the veteran was unable to train for a period because of a medical condition.

BRIEF LEGISLATIVE HISTORY: The Veterans Administration as it exists today was established in 1930 by President Hoover's Executive Order. This act brought under the authority of one agency several already existing programs for veterans.

The history of veterans benefits begins with the history of the United States itself. As early as 1636, the colonies made provisions for those who were injured in military service. In 1776, the Continental Congress established for the first time pensions for disabled veterans.

Before World War II programs existed for veterans' insurance, disability compensation, vocational education and training, and medical and hospital care. With the advent of World War II, an enormous expansion of the Veterans Administration occurred because of both the growing number of veterans and the many new benefits enacted by Congress. The most notable of these new benefits was the GI Bill of 1944. More than 7.8 million veterans participated in one or more training programs under this bill; and over $50 billion dollars in home loans was made. In 1950 another GI Bill passed under which 2.4 million veterans received training and education.

The Veterans Administration underwent a change in philosophy in the late 1960's. The Administration began to seek out Vietnam veterans through outreach programs designed to let them know to which benefits they were entitled. Outreach efforts included the establishment of Veterans Assistance Centers, mailing, and a toll free information number. These efforts resulted in an increase in the number of veterans availing themselves of benefits for which they were eligible.

In 1983, 2.3 million veterans were receiving monthly compensation checks for service-connected disabilities. Another 800,000 veterans were on Veterans Administration pension rolls. About 1.5 million dependents were receiving compensation or pension benefits in 1983.

Recently, health care services provided by the Veterans Administration were expanded when P.L. 97-72 authorized the Veterans Administration to provide certain health care services to any veteran of the Vietnam Era who may have been exposed to dioxin or to a toxic substance in a herbicide or defoliant used for military purposes.

FEDERAL PROGRAM SUMMARY

NAME OF LEGISLATION: Omnibus Budget and Reconciliation Act of 1981 (P.L. 97-35)

MAIN PURPOSE AND OBJECTIVE: The Omnibus Budget and Reconciliation Act of 1981 (OBRA) was a massive initiative that consolidated and reduced spending aross departments of the federal government in order to meet the budget ceiling set by Congress earlier that year. In the process, the Administration decentralized the administration and funding of many Federal programs including some social service, and health programs from the Federal to state government. The philosophy underlying this shift was that state and local governments were in the best position to identify the needs of their respective populations, and therefore should play a more substantial role in the decision making process regarding these programs.

Two major changes in program structure were made to meet the budget ceilings set by Congress: (1) establishment of the block grant program, and (2) ceilings on federal monies spent to reimburse states for entitlement programs for the needy, specifically Medicaid, Aid to Families with Dependent Children (AFDC), and Food Stamps.

BASIC PROVISIONS: The block grant program consolidates many categorical service delivery programs into nine general block grants. A list of the categorical grants collapsed into block grants is attached to this summary. The block grants of special interest in the financing of mental health and related services are:

1. Alcohol, Drug Abuse and Mental Health Block Grant
2. Social Services Block Grant
3. Preventive Health and Health Services Block Grant
4. Maternal and Child Health Block Grant

Provisions for each of these block grants are outlined following this OBRA summary.

There are several characteristics which distinguish the new block grants from the original categorical programs. Under the block grants, federal aid is authorized for a wide range of activities within a broadly defined functional area, instead of being focused on a specific set of purposes. States also have more discretion in identifying problems, designing programs and allocating resources. Under the categorical system, the federal government specified problems, defined eligible populations and prescribed specific services.

Administrative, fiscal reporting, planning and other federally imposed requirements were minimized under the block grants, and some requirements for federal pre-approval, reporting and auditing, were eliminated.

Under the block grant system the tasks of the federal government are: setting funding levels, setting basic program directives, collaborating with the states, gathering information and reporting back to the states, monitoring a states fiscal management, and conducting hearings and investigations regarding basic program needs.

Under the block grant system states are required to perform a number of tasks in order to be eligible for the block grant; specifically,these include developing reports on how funds are to be used, matching federal dollars to state dollars, and restricting the amount of monies used for administrative costs.

Another difference from the categorical system is that most grants allow states to transfer a percentage of a grant to other related small block grants and allow the carryover of funds from one fiscal year to the next.

OBRA's provisions also set forth that block grant legislative provisions would be reviewed by Congress every three years at which time appropriate changes would be made.

Many other changes in OBRA affected social services. Certain provisions place ceilings on the grants to individual states for cash and medical assistance programs for the needy.

OBRA made substantial changes in Medicaid. Its provisions included a reduction in payments to states for 1982, 1983 and 1984. However, states could avoid these reductions by implementing certain fraud and abuse programs.

Under OBRA, reimbursement provisions for hospitals, skilled nursing facilities and intermediate care facilities were changed so that reasonable cost determinations are now made by the state on the basis of cost finding methods approved and verified by DHHS. OBRA also provided for waivers of certain Medicaid provisions.

BRIEF LEGISLATIVE HISTORY ON BLOCK GRANTS: The block grant program has originated from a number of attempts on the part of former presidential administrations to sort out the appropriate role and responsibility of each level of government and from dissatisfaction with the administrative processes that accompanied categorical grants. During the period between 1960 and 1980, there was substantial growth of federal grants-in-aid to the states to address specific human service needs. This growth was accompanied by an increase in the problems associated with the categorical system. These included the distribution of power, authority and responsibility among federal, state and local governments. To counter these problems, prior administrations have enacted programs that have resembled the current structure of the block grant program.

Two of these programs were enacted during the Nixon and Ford Administration. They were the Comprehensive Employment and Training Act of 1974 (CETA) and Title XX of the Social Security Act of 1974.

CETA allowed federal funds to entities designated by the Secretary of Labor to provide job employment and training opportunities to the economically disadvantaged. Although the federal government specified the eligibility criteria for program participants, the designated entities had a wide range of discretion regarding the service delivery model they employed.

A majority of CETA's funds were allocated to local rather than state entities who designated and implemented programs often with little input from the state. The major complaint of the states regarding this administrative structure was that services within each state were fragmented and duplicative.

Title XX of the Social Security Act, in contrast to CETA, allowed for greater state participation in the service delivery model. This program allocated funds directly to states to provide general social services to persons or families for attaining a variety of socially desirable goals. The federal government set forth extensive requirements a state had to meet in order to utilize Title XX funds. Despite these stringent federal requirements the states were allowed more control over how they spent federal funds than was permitted under previous federal programs. These changes were part of a general trend in consolidating and streamlining categorical programs to states and/or local entities which culminated in significant changes in 1981 with the passage of OBRA.

APPENDIX C

BLOCK GRANT OVERVIEW

(from provisions in the Omnibus Reconciliation Act of 1981)

BLOCK GRANT PROGRAM	CITATION IN PUBLIC LAW 97-35 97TH CONGRESS	PRIOR FEDERAL PROGRAMS NOW INCLUDED IN THE BLOCK GRANT	DOES BLOCK GRANT ALLOW TRANSFER OF FUNDS TO OTHER PROGRAMS?	DOES BLOCK GRANT HAVE A CAP OR LID ON ADMINISTRATIVE EXPENSES?	SPECIAL CONDITIONS ATTACHED TO BLOCK GRANT	MUST PROGRAM SUBMIT AN ANNUAL REPORT
PREVENTIVE HEALTH AND HEALTH SERVICES	Title IX Subtitle A Part A 95 Stat. 535-543	Health Incentives; Risk Reduction, Hypertension Control; Home Health Services; Urban Rat Control; Fluoridation; Emergency Medical Services; Rape Crisis Centers	Up to 7% to other three health block grants	Not more than 10%	All agencies that were funded for emergency services in FY81 must be funded in FY82. Hypertension programs must get 75% of funding level in FY82, 60% in FY83	Yes
ALCOHOL, DRUG ABUSE AND MENTAL HEALTH	Title IX Subtitle A Part B 95 Stat. 543-552	Alcoholism Formula and Project Grants; Drug Abuse Formula and Project Grants; Mental Health Services	Up to 7% to other three health block grants	Not more than 10%	Must spend same proportion on mental health as in pre-block grant years. Each mental health center that got a grant in 1980 must get grants in FY82-84	Yes
PRIMARY CARE	Title IX Subtitle A Part C 95 Stat. 552-563	Community Health Centers	No	No funds for Admin expenses	State received a planning grant of $150,000 in FY82. FY83-State match of 20% FY84-State match of 33%	Yes
MATERNAL AND CHILD HEALTH CARE	Title XXI Subtitle D 95 Stat. 818-830	Maternal and Child Health; Crippled Children; SSI Payments/Disabled Children; Lead Paint Poisoning; Sudden Infant Death; Hemophilia; Adolescent Health; Genetic Disease	No	None	State must make match of 43%	Yes
SOCIAL SERVICES (TITLE XX)	Title XXIII Subtitle C 95 Stat. 867-874	Social Services-Title XX Day Care-Title XX State/Local Training-Title XX	Up to 10% to health or low income energy assistance block grants	None	---	Yes - at least every two years
COMMUNITY SERVICES	Title VI Subtitle B 95 Stat. 511-519	Community Action; Community Food and Nutrition; Older Persons Opportunities; State Economic Opportunity Offices; National Youth Sports Program	Up to 5% to low income B.G., Head Start or Older Americans Act	Not more than 5%	90% of funds must go to political subdivisions, not-for-profits, or migrant farm worker projects	Yes
EDUCATION CONSOLIDATION	Title V Subtitle D 95 Stat. 463-480	11 Emergency School Aid Programs; 20 other programs, including Improving Local Education, Gifted and Talented, State Libraries, Ethnic Heritage	No	None	80% of funds must go to local educational agencies; Governor must appoint an advisory council	In FY84 an annual evaluation of effectiveness is required
SMALL CITIES COMMUNITY DEVELOPMENT	Title III Subtitle A Part 1 95 Stat. 384-391	Community Development Block Grant for Non-Entitlement Cities	No	Not more than 2%	State must make a 10% match and consult with local officials about the distribution of funds	Yes
LOW INCOME ENERGY ASSISTANCE	Title XXVI 95 Stat. 893-902	Low Income Energy Assistance Grants	Up to 10% to comm. service or the health block grants	Not More than 10%	Not more than 15% for residential weatherization; a a "reasonable amount" may be reserved for emergency crisis intervention	Yes

FEDERAL PROGRAM SUMMARY

NAME OF LEGISLATION: Alcohol and Drug Abuse and Mental Health Services Block Grant (ADMBG) (as found under Title IX of the Omnibus Budget Reconciliation Act of 1981; Subtitle A-Block Grants, Part B Alcohol, Drug Abuse and Mental Health Services Block Grant)

STATUTORY CITE: 42 U.S.C. 500x

ADMINISTERING FEDERAL AGENCY: Department of Health and Human Services (HHS), Public Health Service, Alcohol, Drug Abuse and Mental Health Administration

GENERAL AREA OF SERVICE COVERED: Alcohol, drug abuse and mental health services

MAIN PURPOSE: Consolidates Federal assistance to states into a single grant for alcohol, drug abuse and mental health services.

BASIC PROVISIONS: This block grant enables each state to plan, establish, maintain and coordinate projects for the development of more effective prevention, treatment and rehabilitation programs and activities to deal with alcohol and drug abuse.

This grant also allocates funds to states for the operation of community mental health centers for the provision of the following services:

- Services for chronically mentally ill individuals, which include identification of chronically mentally ill individuals and assistance to such individuals in gaining access to essential services through the assignment of case managers.
- Identification and assessment of mentally ill elderly individuals and provision of services to them.
- Services for populations which are currently underserved in the state.
- Coordination of mental health and health care services provided within health care centers.
- Services to individuals residing in the community mental health center's service area regardless of their ability to pay for such services.

These mental health centers receiving a grant from the state must provide:

- Outpatient services, especially to children, elderly chronically mentally ill and residents of its mental health service area who have been discharged from in-patient treatment.
- 24-hour-a-day emergency care treatment.
- Day treatment or partial hospitalization services.
- Admission screening for patients being considered for treatment in state mental health facilities to determine the appropriateness of such admissions.
- Consultation and community education services.

These services are to be available and accessible promptly and in a manner which preserves human dignity and assures continuity and high quality care.

FUNDING: The Secretary of HHS allotted to each state for FY 82 the amount which would have been provided to each state under the:

- Community Mental Health Centers Act
- Mental Health Systems Act
- Sections 301 and 312 of the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970
- Sections 409 and 410 of the Drug Abuse Prevention, Treatment and Rehabilitation Act

For allotments beyond FY 82, the Secretary of HHS makes payments to each state based on a formula which takes into account among other things, the financial resources of the state and the size of its population. Also, any unobligated ADMBG funds can be lapsed from one fiscal year to the next. In 1984, $462 million was the ADMBG appropriation. This was increased to $490 million for FY 1985.

ELIGIBILITY: In order to receive an ADMBG a state must submit an application to the Secretary of HHS. The application requires the state to certify that they agree to use the funds allotted to them in accordance with the provisions above. The application also requires that the state legislature conduct public hearings on the proposed use and distribution of funds. The state must also agree to evaluate and monitor programs receiving funds from an ADMBG.

In order to receive an ADMBG a state must also agree to use the funds allotted to it as follows:

- In FY 83 a state had to use 95% of the allotted funds for the prescribed mental health, drug abuse and alcohol activities.
- In FY 84 a state had to use 85% allotted under the ADMBG for mental health, drug abuse and alcohol activities described above.

A state must also agree to use funds for alcohol and drug abuse as follows:

- Not less than 35% must be made available for alcoholism and alcohol abuse programs.
- Not less than 35% must be made available for programs related to drug abuse.
- Not less than 20% of the amount used for alcohol or drug abuse must be used for prevention and intervention programs designed to discourage the abuse of alcohol or drugs.

A state, in order to be eligible for funds, must have a system in place to protect client confidentiality in connection with services funded by the ADMBG.

A state may only use Federal funds to support and not supplant state, local and other non-federal funds.

OTHER STATE REQUIREMENTS: A state may not use its ADMBG allotment to provide inpatient services or make cash payments to intended recipients of health services, or to purchase land or major medical equipment or construct any buildings. A state may not use its allotment to provide financial assistance to any entity other than a public or nonprofit entity.

A state must prepare an annual report on its activities, must establish fiscal control and fund accounting procedures to assure proper disbursal of ADMBG funds, and perform an annual audit.

ADMINISTRATIVE COST ALLOWANCE: Of the amount paid to each state, not more than 10% may be used for administering ADMBG funds.

TRANSFER ALLOWANCE: A state may tranfer up to 7% of its ADMBG to any of the following block grants:

- Preventive Health and Health Services Block Grant
- Primary Care Block Grant
- Maternal and Child Health Block Grant

SIGNIFICANT AMENDMENTS OF 1984:

On October 4, 1984, the House-Senate Conference Committee reported revised ADMBG legislation. The changes this bill made with regard to the ADM Block Grant included provisions for a new formula for distribution to states, increased transferability between blocks, and earmarking of some ADMBG funds.

The bill as reported out of the conference committee modified the previous formula for distributing block grant monies to the state. The new formula reflects a state allocation based upon relative population and per capita income of each state. The bill also provides a "hold harmless" clause for states, stipulating that no state will receive an amount less than the allotment received in FY 84. The bill also increases the percentage that a state could transfer between alcohol, drug abuse and mental health services from 15% to 25%.

The bill also extends the requirement that states continue to make grants to community mental health centers that would have been entitled to receive funds in FY 85-87 under the previous Community Mental Health Center Act. Other provisions require states to allocate not less than 5% of its total block grant allotment to initiate and expand alcohol and drug abuse services for women. It also requires that 10% of the state mental health allotment be used for new services for severely disturbed children and adolescents and used to establish new comprehensive community mental health services for unserved or underserved areas or groups.

The bill authorizes, but does not require, each state to use ADMBG monies to establish a mental health planning council which will serve as an advocate for chronically mentally ill individuals, seriously mentally ill individuals and other persons with mental illness or emotional problems. This council would also be responsible for monitoring, planning, coordinating, receiving and evaluating mental health services. The provisions of the bill permit community mental health centers that receive block grant monies to provide psychosocial rehabilitation services.

The new ADMBG legislation also provides monies for mental health service demonstration projects; establishes an Alcohol, Drug Abuse and Mental Health Advisory Council which assesses national needs for these services and the extent these needs are being met; and extends the authorization of appropriations for the National Institute on Alcohol Abuse and Alcoholism (NIAAA) and the National Institute of Drug Abuse (NIDA).

APPENDIX C

ALLOCATION OF FEDERAL FUNDS

COMMUNITY MENTAL HEALTH CENTERS ACT, 1965-1981

ALCOHOL AND DRUG ABUSE AND MENTAL HEALTH BLOCK GRANT, 1982

State	% of 1980 Population	% of '65-'81 CMHC Obligations	ADM Block Grant Allocation % to State	Mental Health % of ADM Block Allocation
AL	1.689%	2.216%	2.023%	66.80%
AK	.174	.180	.414	14.09
AZ	1.187	1.537	1.952	46.21
AR	.997	2.288	1.360	65.88
CA	10.280	8.739	9.623	33.30
CO	1.258	2.022	1.483	45.77
CT	1.332	.845	1.514	34.77
DE	.259	.240	.264	4.47
FL	4.182	4.789	5.243	52.43
GA	2.359	2.400	2.095	66.94
HI	.416	.371	.553	49.80
ID	.412	.588	.292	36.50
IL	4.957	2.680	3.796	36.44
IN	2.384	4.388	4.232	85.76
IA	1.270	.224	.474	1.66
KS	1.028	1.175	.705	54.17
KY	1.590	3.028	.776	29.16
LA	1.833	.671	1.017	13.81
ME	.490	1.239	.767	49.78
MD	1.833	.737	.840	8.19
MA	2.501	3.728	3.977	54.95
MI	4.033	2.220	3.059	28.22
MN	1.776	.795	.830	24.45
MS	1.096	1.435	.925	71.34
MO	2.142	1.972	1.871	56.82
MT	.342	.498	.407	49.61
NE	.683	.898	.494	43.49
NV	.349	.544	.613	45.24
NH	.401	.826	.810	71.42
NJ	3.205	3.990	4.508	50.69
NM	.565	1.069	1.091	49.47
NY	7.644	5.814	8.825	22.03
NC	2.553	2.320	2.101	59.19
ND	.284	.477	.201	24.49
OH	4.703	5.059	5.203	67.55
OK	1.310	1.739	1.713	74.48
OR	1.143	.541	1.132	39.93
PA	5.164	7.840	5.516	51.98
RI	.412	.545	.935	54.84
SC	1.340	1.618	1.297	63.59
SD	.300	.387	.623	62.95
TN	1.984	1.871	1.471	68.22
TX	6.188	4.444	3.924	39.93
UT	.637	.913	.716	43.40
VT	.223	.671	.680	63.50
VA	2.324	1.400	1.555	41.51
WA	1.796	1.690	1.958	51.59
WV	.843	1.330	.764	62.89
WI	2.049	.690	.892	5.45
WY	.204	.237	.146	41.70
DC	.277	.620	.491	4.32
PR	1.391	1.151	1.487	38.85
Terr.	.579	.324	.362	67.11
TOTAL	100%	100%	100%	47.68%

Source: The Community Mental Health Services Network: A Statistical Profile, National Institute of Mental Health, Rockville, MD, February, 1983.

STATE-BY-STATE ALLOTMENT OF ADAMH BLOCK GRANT FUNDS FOR FISCAL 1985

STATE	FY 84 ALLOTMENT	FY 85 AGREEMENT*	% INCREASE
Alabama	$9,328,000	$9,328,000	—
Alaska	$2.093,000	$2,093,000	—
Arizona	$9,004,000	$9,004,000	--
Arkansas	$6,385,000	$6,385,000	--
California	$43,802,000	$48,748.000	11.29%
Colorado	$7,004,000	$7,004,000	—
Connecticut	$6,985,000	$6,985,000	--
Delaware	$1,428,000	$1,428,000	--
District of Columbia	$2,467,000	$2,467,000	--
Florida	$24,033,000	$24,033,000	--
Georgia	$9,757,000	$11,060,000	13.35%
Hawaii	$2,827,000	$2,827,000	—
Idaho	$1,423,000	$1,649,000	15.89%
Illinois	$17,177,000	$19,510,000	13.57%
Indiana	$19,524,000	$19,524,000	—
Iowa	$2,292,000	$2,914,000	27.13%
Kansas	$3,451,000	$3,950,000	14.47%
Kentucky	$3,654,000	$4,528,000	23.92%
Louisiana	$4,648,000	$5,620,000	20.91%
Maine	$3,733,000	$3,733,000	—
Maryland	$3,982,000	$4,852,000	21.83%
Massachusetts	$18,240,000	$18,240,000	--
Michigan	$13,962,000	$15,895,000	13.84%
Minnesota	$4,043,000	$4,919,000	21.65%
Mississippi	$4,481,000	$5,139,000	14.69%
Missouri	$8,690,000	$9,791,000	12.67%
Montana	$2,153,000	$2,153,000	—
Nebraska	$2,333,000	$2,677,000	14.73%
Nevada	$2,897,000	$2,897,000	—
New Hampshire	$3,844,000	$3,844,000	--
New Jersey	$20,647,000	$20,647,000	—
New Mexico	$4,934,000	$4,934,000	--
New York	$40,097,000	$40,097,000	—
North Carolina	$9,508,000	$10,934,000	14.99%
North Dakota	$1,016,000	$1,160,000	14.19%
Ohio	$23,585,000	$23,585,000	—
Oklahoma	$7,775,000	$7,775,000	—
Oregon	$5,359,000	$5,937,000	10.79%
Pennsylvania	$25,114,000	$25,114,000	—
Rhode Island	$4,417,000	$4,417,000	--
South Carolina	$5,877,000	$6,662,000	13.35%
South Dakota	$3,100,000	$3,100,000	—
Tennessee	$6,667,000	$7,777,000	16.65%
Texas	$18,064,000	$21,283,000	17.81%
Utah	$3,428,000	$3,800,000	10.84%
Vermont	$3,313,000	$3,313,000	—
Virginia	$7,193,000	$8,368,000	16.33%
Washington	$8,977,000	$8,977,000	—
West Virginia	$3,812,000	$4,280,000	12.28%
Wisconsin	$4,218,000	$5,247.000	24.39%
Wyoming	$661,000	$761,000	15.17%
Puerto Rico and others	$8,598,000	$8,635,000	4.30%

*Based on a conference agreement to give the block grant $490 million and a revised state allocation formula.

Source: Excerpted from Mental Health Reports
October 10, 1984 p.2

FEDERAL PROGRAM SUMMARY

NAME OF LEGISLATION: Social Services Block Grant (SSBG) (as found in the U.S. Statutes under Title XXIII of the Omnibus Budget Reconciliation Act of 1981; Subtitle C - Block Grants for Social Services)

STATUTORY CITE: 42 U.S.C. 1397

ADMINISTERING FEDERAL AGENCY: Department of Health and Human Services (HHS), Office of Human Development Services

GENERAL AREA OF SERVICE COVERED: Social Service programs designed to meet the needs of low-income persons

MAIN PURPOSE: Consolidates federal assistance to states for social services into a single grant which would increase a state's flexibility in using this grant. It was also the intent of this legislation that the services provided with SSBG funding be directed at one or more of five national goals. These goals are:

- Achieving or maintaining economic self-support to prevent, reduce or eliminate dependency.
- Achieving or maintaining self-sufficiency, including reduction or prevention of dependency.
- Preventing or remedying neglect, abuse or exploitation of children and adults unable to protect their own interests, or preserving, rehabilitating or reuniting families.
- Preventing or reducing inappropriate institutional care by providing for community-based care, home-based care, or other forms of less intensive care.
- Securing referral or admission for institutional care when other forms of care are not appropriate, or providing services to individuals in institutions.

BASIC PROVISIONS: This block grant enables each state to provide services which are directed at these goals. These services include, but are not limited to:

- Child care services
- Protective services for children and adults
- Services for children and adults in foster care
- Homemaker services

- Day care services for adults
- Transportation services
- Family planning services
- Training and employment services
- Information, referral and counseling services
- Preparation and delivery of meals
- Health support services
- Services to meet the special needs of children, aged, mentally retarded, blind, emotionally disturbed, physically handicapped, alcoholics and drug addicts

SSBG funds may be used for administering, planning and evaluating programs delivering these services or may be used for training personnel delivering these services. The state may also use an unspecified portion of the SSBG to purchase technical assistance for program administration or development.

FUNDING: The Secretary of Health and Human Services allots to each state an amount based on a formula which takes into account the monies previously received by the state under:

- Title XX Social Services
- Title XX Training
- Title XX Day Care

This formula also takes into account the population of the state as it compares to the population of the nation.

ELIGIBILITY: In order to be eligible for a Social Services Block Grant a state must submit an application to the Secretary of Health and Human Services. Included in the application process is the requirement that states develop and make public a report on how funds are to be used prior to expending funds.

OTHER STATE REQUIREMENTS: A state may not use any portion of the Social Services Block Grant for purchasing or improving land, construction of any building, providing cash payments to individuals for subsistence or room and board, payment of wages, provision of medical care or for social services provided in a hospital, skilled nursing facility, or intermediate care facility. A state may not use any portion of the Social Services Block Grant to provide educational services which the state makes generally available to its residents without cost.

A state must prepare a report at least every two years on its activities funded by the Social Services Block Grant. A state must also perform an audit of its Social Services Block Grant expenditures.

Previous requirements that at least 50% of funds be used for services for welfare recipients and that services be limited to families with incomes below a certain percentage of a state's median income are removed.

ADMINISTRATIVE COST ALLOWANCE: There are no limits on the amount of funds that may be used by the state for administering Social Services Block Grant funds.

TRANSFER ALLOWANCE: A state may transfer up to 10% of its Social Services Block Grant allotment for use in the following block grants:

- Preventive Health and Health Services Block Grant
- Maternal and Child Health Block Grant
- Primary Care Block Grant
- Alcohol, Drug Abuse and Mental Health Block Grant

FEDERAL PROGRAM SUMMARY

NAME OF LEGISLATION: Preventive Health and Health Services Block Grant (PHHSBG) (as found under Title IX of the Omnibus Budget Reconciliation Act of 1981; Subtitle A - Block Grants; Preventive Health and Health Services)

STATUTORY CITE: 42 U.S.C. 300W

ADMINISTERING FEDERAL AGENCY: Public Health Service, Health and Human Services (HHS), Centers for Disease Control

GENERAL AREA OF SERVICE COVERED: Preventive health service programs and comprehensive health services

MAIN PURPOSE: Consolidates Federal assistance to states into a single grant for preventive health and health service programs.

BASIC PROVISIONS: This block grant enables each state to maintain and strengthen their leadership in planning, promoting, coordinating and evaluating health care for mothers and children who do not have access to adequate health care.

Specifically this grant allocates funds to states:

- To provide preventive health service programs for the control of rodents and community and school-based fluoridation programs.
- To establish and maintain preventive health service programs for screening for the detection, diagnosis, prevention, and referral for treatment of, and follow-up on compliance with treatment prescribed for hypertension.
- To provide community-based programs for the purpose of demonstrating and evaluating optimal methods for organizing and delivering comprehensive preventive health services to defined populations, comprehensive programs designed to deter smoking and the use of alcoholic beverages among children and adolescents, and other risk-reduction and health education programs.
- To provide comprehensive public health services.
- To demonstrate the establishment of home health agencies (as defined in Section 1861(m) of the Social Security Act) in areas where the services of such agencies are not available. Amounts provided for such agencies may not be used for the direct provision of health services.

- To study and plan for emergency medical services systems and to establish, expand and improve such systems.

- To provide services to rape victims and for rape prevention.

FUNDING: The Secretary of HHS allots to each state for FY 82 the amount which would have been provided to each state under the

- Emergency Medical Services
- Health Incentive Grants
- Hypertension Control Grant
- Rodent Control Grant
- Community and School Based Fluoridation Grant
- Health Education and Risk Reduction Grant
- Home Health Grant
- Rape Crises Center Grant

For allotments beyond FY 82 the Secretary of HHS makes payments to each state based on a formula which takes into account, among other things, the financial resources of the state and the population of the state. Any unobligated PHHSBG funds can be lapsed from one year to the next. The state must agree that these PHHS block grant fund will support and not supplant state, local and other non-Federal funds.

ELIGIBILITY: In order to receive a PHHSBG each state must submit an annual application to HHS. The application requires the state to certify that they agree to use the funds allotted to them in accordance with the provisions above. The application process also requires that the state legislature certify that they have conducted public hearings on the proposed distribution of funds and will provide HHS with a description of the intended use of the funds.

The state, in order to be eligible for funds, must have a system in place to protect the confidentiality of patient and rape victim records.

OTHER STATE REQUIREMENTS: A state may not use its PHHS allocation to provide inpatient services, make cash payments to intended recipients of health services, purchase land or major medical equipment or construct any building, to satisfy any requirement for the expenditure of non-Federal funds as a condition for the receipt of Federal funds (i.e. Medicaid) or provide financial assistance to any entity other than a public or non-profit private entity.

The state must also agree to make grants for preventive health service programs for hypertension in amounts equal to:

- 75% of the total amount provided by HHS to the state under Section 317 for such programs in FY 82.

- 70% of the total amount provided by HHS to the state under Section 317 for such programs in FFY 83.

- 60% of the total amount provided by HHS to the state under Section 317 for such programs in FFY 84.

States must fund at unspecified levels Emergency Medical Services programs funded in FFY 81.

A state must prepare an annual report on its activities, must establish fiscal control and fund accounting procedures to assure proper disbursal of PHHSBG funds and perform an annual audit.

ADMINISTRATIVE COST ALLOWANCE: Of the amount paid to each state, not more than 10% may be used for administering PHHSBG funds.

TRANSFER ALLOWANCE: A state may transfer up to 7% of its PHHS to any of the following block grants:

- Alcohol and Drug Abuse and Mental Health Block Grant
- Primary Care Block Grant
- Maternal and Child Health Block Grant

but they may transfer no more than 3% of the fiscal year's allotment during the first three quarters of that fiscal year.

FEDERAL PROGRAM SUMMARY

NAME OF LEGISLATION: Maternal and Child Health Services Block Grant (MCHSBG) (as found in the U.S. Statutes under Title XXI of the Omnibus Budget Reconciliation Act of 1981; Subtitle D-Maternal and Child Health Services Block Grant)

STATUTORY CITE: 42 U.S.C. 1305

ADMINISTERING FEDERAL AGENCY: Department of Health and Human Services (HHS), Public Health Service, Health Resources and Service Administration

GENERAL AREA OF SERVICE COVERED: Health care to mothers and children

MAIN PURPOSE: Consolidates Federal assistance to states for the expressed purpose of planning, promoting, coordinating and evaluating health care for mothers and children and providing health services for mothers and children who do not have access to adequate health care.

Another purpose of the grant is to reduce infant mortality and the incidence of preventable disease and handicapping conditions among children, to reduce the need for inpatient and long-term care services, to increase the number of children (especially pre-school children) appropriately immunized against disease and the number of low-income children receiving health assessments and follow-up diagnostic and treatment services, and otherwise to promote the health of mothers and children (especially by providing preventive and primary care services for low-income children, and prenatal, delivery, and postpartum care for low-income mothers).

BASIC PROVISIONS: This block grant enables each state:

- To provide rehabilitation services for blind and disabled individuals under the age of 16 receiving benefits under Title XVI of this Act.
- To provide services for locating, and for medical, surgical, corrective, and other services, and care for, and facilities for diagnosis, hospitalization, and aftercare for, children who are crippled or who are suffering from conditions leading to crippling.

The grant enables HHS to provide for special projects of regional and national significance, research, and training with respect to maternal and child health and crippled children, for genetic disease testing, counseling, and information development and dissemination programs.

Funds may be used for planning, administration, education, evaluation and purchasing equipment from the federal government.

FUNDING: The Secretary of HHS allots to each state the amount based on a formula which includes the amounts allotted to each state under the previous programs:

- Title V of the Social Security Act: Maternal and Child Health and Crippled Children Services
- SSI for Disabled Children
- Lead-Based Paint Poisoning Prevention
- Sudden Infant Death Syndrome
- Hemophilia Treatment Centers
- Adolescent Pregnancy
- Genetic Diseases Program

and also takes into account the number of low-income children in the state in proportion to the number of low-income children nationwide. In 1984, expenditures nationally for the Maternal and Child Health Block Grant were $399 million.

ELIGIBILITY: In order to receive a PHHSBG a state must submit an application to the Secretary of HHS. Included in the application should be a report which contains a needs assessment, statement of goals and objectives, services to be provided, characteristics of clients and data the state intends to collect. A state must also certify that funds will be used for the purpose of former categorical programs now within the block grant.

OTHER STATE REQUIREMENTS: A State may not use the MCHS Block Grant for inpatient services provided to crippled children or to high risk pregnant women and infants, cash payments to intended recipients of health services or to purchase land or major medical equipment or construct any buildings. The state will not impose charges on low-income mothers.

The state agency administering the MCHSBG must coordinate with the state's Medicaid early and periodic screening, diagnosis and treatment program to ensure that such programs are carried out without duplication of effort.

ADMINISTRATIVE COST ALLOWANCE: Of the amount paid to each state, there is no limit on the amount to be used for administering the Maternal and Child Health Services Block Grant.

TRANSFER ALLOWANCE: A state may not transfer any of its Maternal and Child Health Services Block Grant to any other block grant.

MATCHING REQUIREMENTS: This is one of the few block grants that require matching funds from a state. To receive a Maternal and Child Health Services Block Grant a state must match every four Federal dollars with three State dollars.

FEDERAL PROGRAM SUMMARY

NAME OF LEGISLATION: National Housing Act of 1937

STATUTORY CITE: 12 U.S.C. 1701 and Other Cites

ADMINISTERING FEDERAL AGENCY: Department of Housing and Urban Development (HUD)

GENERAL AREA OF SERVICE COVERED: Mortgage insurance, low interest loans, direct grants to local communities, and rent supplements

MAIN PURPOSE: To provide good quality housing within the price range of low and moderate income families

BASIC PROVISIONS: The federal government supports housing for lower income families with both subsidies for the construction of housing aimed to serve that population and subsidies to owners for renting to them. "Supply programs" include mortgage insurance, low interest loans, and other policies designed to directly increase the amount of low-rent housing available. In contrast, "demand programs" help low-income persons acquire housing by supplementing the amount they can afford to pay for their housing, or at least the amount policymakers decide they can afford. This type of program is designed to enhance the ability of lower income families to acquire housing in the private market. A series of programs sponsored by HUD address both the supply and demand issues.

FUNDING: Various programs authorize low-interest loans, insure mortgage loans, or promote various methods to directly increase the amount of low-rent housing available. Other programs help low-income persons acquire housing by supplementing the amount they can afford to pay for their housing.

ELIGIBILITY: Each program sets up standards of eligibility. Some of the most commonly served groups of people include: low-income, elderly, developmentally disabled, physically handicapped, chronically mentally ill, and veterans. The vast majority of these programs do establish some type of income limitations.

BRIEF LEGISLATIVE HISTORY: The U.S. Housing Act of 1937 inaugurated the first major American experiment in housing directly and explicitly subsidized with public funds. This act authorized federal loans for the development of public housing and "slum clearance" projects, and provided for either capital grants or annual contributions to assure their continued availability to low-income people. Although the original legislation has been reworked and elaborated over the years, the 1937 Act established the basic framework for the "public housing program". Some of the additions and changes made to this original legislation are discussed below.

PROGRAM COMPONENTS: Some of the most important sections of the National Housing Act are identified below.

Section 8 Rental Assistance created by the Housing and Community Development Act of 1974, makes payments to housing owners on behalf of lower income families, including elderly and handicapped individuals, at rates equal to the difference between an amount of rent seemed affordable and normal market rents. An authorized Public Housing Agency may apply for the section 8 program to assist low income persons. At the end of 1983 1.76 million units were receiving subsidies under this program.

Section 202 of the Housing Act of 1959, provides financing for the construction of rental and cooperative housing designed specifically for the elderly (62 years of age or older), developmentally disabled, physically handicapped, or chronically mentally ill. Under 202, direct loans are used to finance construction and rehabilitation. Also, families whose incomes fall within 50 percent of the median family income for the area in which the project is located may benefit from subsidy payments under Section 8.

This program is geared toward providing a supportive and adequate environment. Most of these projects contain community rooms, recreation facilities and laundry facilities. However, they do not generally provide medical care, nursing care, or physical therapy.

Private non-profit corporations and consumer cooperatives may apply for the funds. In FY 83, $752.9 million was appropriated for this program.

Section 232 of the National Housing Act, as amended, provides assistance primarily to those needing skilled or intermediate nursing care. Also, space for day care can be provided in Section 232 supported facilities. This program provides mortgage insurance to help finance the construction or renovation of facilities designed to accommodate 20 or more patients who require nursing home care and related medical services, or those in need of minimum but continuous care provided by licensed or trained personnel. In fiscal year 1983, 62 projects (8,672 beds) valued at $267,446,800 were insured.

Under Title I of the Housing and Community Development Act of 1974, as amended, HUD awards block grants to local governments to fund a variety of community development activities which previously had been eligible for federal assistance. Under eight separate categorical grant programs. The Community Development Block Grant (CDBG) program provides large cities and urban counties with a guaranteed amount (entitlement) determined by a formula which takes into account factors such as population, housing overcrowding, and extent of poverty in a community. Smaller communities compete for allocations of CDBG discretionary funds, which are awarded by HUD.

Localities may undertake a wide range of activities directed toward neighborhood revitalization, economic development, and provision of improved community facilities and services. Entitlement communities develop their own programs and funding priorities as long as programs/activities conform to the statutory standards and program regulations. Some of the specific activities that can be carried out with community development funds include acquisition of real property, relocation and demolition, rehabilitation of residential and nonresidential structures.

All projects or activities must either benefit low and moderate income persons, aid in the prevention or elimination of slums and blight, or meet other community development needs having a particular urgency.

Section 312 of the Housing Act of 1964 was created to provide direct federal rehabilitation loans to property owners in areas receiving assistance under other federal programs such as Community Development Block Grant, Urban Homesteading, and Urban Renewal. Properties, at a minimum, must be brought up to local code standards. This program provides loans for home rehabilitation to families who cannot afford to fix up their homes through any other means. Loans are given at very low interest rates with the maximum amount borrowed per family being $33,500.

Congregate Housing Services Program Act of 1978 authorized HUD to award grants to public housing authorities and Section 202 housing sponsors to provide nutritional meals and supportive services for tenants in their projects. Contracts under the program run from three to five years. The services provided can not duplicate those already available under other programs, and planning is supposed to be coordinated with the local area agency on aging. Fees may be charged eligible individuals (eligibility is determined by a "professional assessment committee") for meals and other services if the fees are reasonable and calculated on the basis of a sliding scale related to income.

At the end of 1983, 62 congregate housing projects serving over 2,000 elderly persons were in operation. In the fiscal year 1983 HUD and Independent Agencies Appropriation Act provided $3.5 million to continue the funding of congregate projects which were already in existence, and an additional $500,000 for new projects in rural areas. In the Housing Act of 1983, Congress authorized $4 million for the congregate services program.

FEDERAL PROGRAM SUMMARY

NAME OF LEGISLATION: Housing Act of 1949

STATUTORY CITE: Various cites including 42 U.S.C. 1472, 42 U.S.C. 1474, 42 U.S.C. 1485, 1490a

ADMINISTERING FEDERAL AGENCY: Farmers Home Administration (FmHA), U.S. Department of Agriculture

GENERAL AREA OF SERVICE COVERED: Housing programs for nonfarm rural and small town residents with excellent mortgage loan programs

MAIN PURPOSE: To provide credit basically for low-income nonfarm rural and small town residents to obtain and repair housing

BASIC PROVISIONS: The Farmers Home Administration (FmHA) is the primary housing agency for the rural areas of the country. In 1949, housing programs for nonfarm rural and small town residents were authorized, and good FmHA mortgage loan programs are available today for those populations.

Funds may be used to buy, build, improve, or relocate homes and related facilities, and to buy minimum, adequate building sites for low and moderate income families. In 1972, FmHA was authorized to guarantee or insure loans made by private lenders to rural residents of any income level.

FUNDING: Farmers Home Administration programs are quite different from those of HUD/FHA because they operate independently of private lenders. With the one exception of its loan guarantee program, FmHA is designed to serve those for whom local private credit sources are inadequate or nonexistent. FmHA loans funds directly to the homemaker at an interest rate below the private market rate and continues to service its loans as the mortgagee.

FmHA obtains the funding it uses to make loan advances from the Rural Housing Insurance Fund, a revolving source of loan money. Each rural housing borrower signs a promissory note providing for monthly payments. Notes obtained from FmHA borrowers are insured by FmHA and sold to the Federal Financing Bank. Proceeds from these sales are returned to the Fund.

Losses from the Fund occur as the result of the fact that the interest rate FmHA charges its borrowers is below the rate paid to purchasers of its insured notes. The agency thus provides an interest subsidy to its borrowers.

In a limited number of programs, FmHA also provides more direct interest subsidies and grants. These subsidies are paid out of the Fund and are subsequently replenished by Congressional appropriation.

ELIGIBILITY: FmHA makes loans and grants for housing available only in rural areas, the sole exception being its farm labor program, which is available in urban areas. Also, most programs have some income limitations for qualifying applicants.

BRIEF LEGISLATIVE HISTORY: The Housing Act of 1949 authorized housing programs for nonfarm rural and small town residents to be administered under the Farmers Home Administration of the U.S. Department of Agriculture. Three of the more important housing programs offered by FmHA include: Section 502 Rural Housing Loans, Section 504 Rural Housing Loans and Grants, and Section 515 Direct Loans. These three sections of the Farmers Home Administration were all part of the original Housing Act of 1949. Of course since that time some adjustments have taken place. These basic program components are discussed and explained in the following section.

PROGRAM COMPONENTS: Three of the more important housing programs offered by the Farmers Home Administration (FmHA) are outlined below.

Title V of the Housing Act of 1949, Section 502 Rural Housing Loans, as amended was established to provide direct loans to rural low and moderate income families for the construction, rehabilitation, repair, or purchase of housing at interest rates as low as 1 percent. Dwellings financed must be modest in size, design, and cost and located in a place that is rural in character and does not exceed 10,000 population or in a place whose population is between 10,000 and 20,000 but not in a Metropolitan Statistical Area (MSA). Also, there must be a serious lack of mortgage credit for low and moderate income families in this area.

To be eligible for the program, a family must be unable to obtain credit on affordable terms from other sources, but have sufficient income to cover mortgage payments, maintenance costs and other living expenses. The applicant's income may not exceed the low income limits based on 80 percent of an area's median income, ranging from $11,500 to $18,000 except in the high cost area of Alaska where the range is from $24,000 to $27,000. Also, the applicant must be an owner, or when the loan is closed, become the owner of a dwelling and the site on which it is located, in a rural area.

Between fiscal years 1965 and 1980 more than 1.3 million loans were obligated under Section 502. In fiscal year 1983, 65,467 loans were made at a cost of $2,137,125,930. The average loan for new construction is $40,075.

Title V of the Housing Act of 1949, Section 504 Rural Housing Loans and Grants, as amended was established to assist very low income owneroccupants in rural areas who do not qualify for Section 502 loans to repair or improve the sanitary conditions and safety conditions of their dwellings. This includes repairs to the foundation, roof, or basic structure as well as water and waste disposal systems and weatherization. Funds cannot be used simply to improve a house's appearance.

Loans bear an interest rate of one percent and are repaid over a period of up to 20 years. Maximum loan assistance is $7,500 to any eligible person and maximum grant assistance of $5,000 to any eligible elderly person for home improvement. No family may receive more than $7,500 in loans and grants combined nor more than $5,000 in grants.

An applicant must own and occupy a home in a rural area; be without sufficient income to qualify for a Section 502 loan; have sufficient income to repay the loan; and be a citizen of the United States or reside in the United States after having been legally admitted for permanent residence or on indefinite parole. Grant recipients must be 62 years of age or older and be unable to repay the part of the assistance received as a grant. Applicant's income may not exceed the very low-income limit set forth in FmHA instructions. Very low-income limits range from $5,000 to $11,500 depending on an area's median income.

In FY 1983, 2,288 loans were made at an average cost of $3,233; 3,845 grants were made at an average of $3,076. Loan totals in FY 83 were approximately $7 million and grants $12.5 million.

Section 515 of the Housing Act of 1949 as amended provides direct loans for the construction, purchase, improvement, or repair of rental or cooperative housing for low and moderate income families, the elderly, and the disabled. Housing as a general rule will consist of multi-units with two or more family units and any appropriately related facilities. Funds may also be used to provide recreational service facilities appropriate for use in connection with the housing and to buy and improve the land on which the buildings are to be located. Loans may not be made for nursing, special care, or institutional-type homes.

Applicant eligibility is extended to individuals, cooperatives, public agencies and private for profit and non-profit organizations. Interest rates vary from the market rate for profit-oriented borrowers, to as low as one percent for non-profit and so-called "limited profit" borrowers who rent to low and moderate income families. However, applicants must be able to assume the obligations of the loan, furnish adequate security, and have sufficient income for repayment. Loans may be made in communities up to 10,000 people and places up to 20,000 population under certain conditions.

They must have ability to maintain the housing for purposes for which the loan was made.

The FmHA also has its own rent subsidy program for Section 515 projects. It is administered like HUD's Section 8 program, paying the difference between a percentage of the tenant's income and his total approved rent. Like the Section 8 new construction and rehabilitation programs, this assistance is tied to the unit and not the tenant family.

Finally, through Section 515, FmHA participates in a congregate housing or an assisted residential living environment demonstration. Twelve million dollars were set aside for construction loans to build congregate facilities in 10 states and 2 Indian reservations.

In fiscal year 1983, $801,997,400 in loans were made to provide housing for 24,200 families. Initial insured loans to individuals averaged $250,000; initial insured loans to organizations averaged $750,000.

ANNUAL FEDERAL EXPENDITURES FOR SELECTED PROGRAMS THAT PROVIDE FINANCING FOR MENTAL HEALTH AND RELATED SERVICES

The appropriations information listed below has been obtained from the Budget of the United States Government, Office of Management and Budget. Specific pieces of legislation provide statutory parameters and guidance for individual programs. However, program listings occur as part of larger departments.

Because of the complexity and size of the U.S. budget, figures have been selected for specific programs for presentation. Departments and administrative areas for these programs are indicated. Actual 1984 and estimated 1985 expenditures are presented for each program selected. All figures are presented in thousands of dollars.

DEPARTMENT OF EDUCATION

Education for the Handicapped

	1984 Act.	1985 Est.
State Grants		
State Grant Program	1,082,180	1,241,750
Pre-School Incentive State Grants	32,064	30,087
Special Purpose Funds (including deaf blind centers, transitional services, etc.)	145,440	197,125
Total	1,259,684	1,468,962

Rehabilitation Services and Handicapped Research

Direct Program Activities	1984 Act.	1985 Est.
Vocational Rehabilitation State Grants	1,037,800	1,100,000
Special Purpose Funds:		
Client Assistance	6,000	6,300
Service Projects	27,900	32,800
Helen Keller Center	4,000	4,200
Independent living	19,400	27,000
Training	22,000	22,000
National Institute for Handicapped Research	37,242	39,258
Evaluation	2,000	2,000
Total Program	1,156,342	1,233,558

Vocational Education

	1984 Act.	1985 Est.
State Programs:		
Basic Grants	662,859	727,128
Consumer and Homemaker Education	36,792	33,280
State Councils	7,027	7,514

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Resources and Services

Direct Program Activities	1984 Act.	1985 Est.
Maternal and Child Health Block Grant	398,964	478,000
Community Health Centers	350,122	375,000
Black Lung Clinics	3,120	3,300
Migrant Health	42,000	44,300
Family Planning	139,972	142,500
Home Health	5,000	3,000

Centers for Disease Control

Direct Program Activities	1984 Act.	1985 Est.
Preventive Health Block Grant	88,187	89,500
Immunization	54,688	54,745
Infectious Disease Prevention	51,633	57,707

Alcohol, Drug Abuse, and Mental Health Administration

Direct Program Activities	1984 Act.	1985 Est.
ADM Services Block	462,000	490,000
Mental Health (NIMH)		
Research	174,964	195,200
Planning and Demonstrations	7,003	13,000
Training	36,360	40,000
Direct Operations	32,708	34,426

Health Care Financing Administration

	1984 Act.	1985 Est.
Grants To States For Medicaid		
Medicaid Vendor Payments	19,169,046	21,778,942
State and Local Administration	1,043,088	1,205,660
	20,212,134	22,984,602
Medicare (Part A) Federal Hospital Insurance Trust Fund		
Benefit Payments	41,643,538	47,909,896
Administration	646,066	685,254
Medicare (Part B) Federal Supplementary Medical Insurance Trust Fund		
Benefit Payments	19,451,868	22,095,000
Administration	916,492	981,364
Experiments and Demonstrations	8,394	8,076

Human Development Services

	1984 Act.	1985 Est.
Social Services Block Grant	2,700,360	2,725,000
Administration for Children, Youth and Families		
Head Start	995,651	1,075,059
Child Abuse State Grants	6,675	9,000
Child Abuse Discretionary	9,421	17,000
Runaway Youth	22,624	23,250
Administration on Aging		
State Agency Activities	21,673	
Title III Services and Meals	639,509	668,900
Grants to Indian Tribes	5,735	7,500
Research, Training, Discretionary	22,162	25,000
Federal Council on Aging	172	200

Administration on Developmental Disabilities (DD Act)

	1984 Act.	1985 Est.
State Grants and Advocacy	52,150	64,000
Special Projects and UAF's	10,103	11,700

SOCIAL SECURITY ADMINISTRATION

Supplemental Security Income Program (SSI)

	1984 Act.	1985 Est.
Federal Benefit Payments	7,481,334	8,556,000

Federal Disability Insurance Trust Fund (SSDI)

	1984 Act.	1985 Est.
Benefit Payments	17,783,796	19,106,451
Administration	585,061	754,721

DEPARTMENT OF LABOR

Training and Employment Services (Job Training Partnership Act)

	1984 Act.	1985 Est.
Grants to States		
Block Grant	3,300,764	1,886,151
Summer Youth Employment and Training	824,548	824,549
Dislocated Worker Assistance	262,687	235,344

DEPARTMENT OF AGRICULTURE

Food and Nutrition Services

	1984 Act.	1985 Est.
Food Stamp Program		
Benefits	10,726,354	10,523,314
State Administration	807,270	840,000
Other	77,997	91,414
Total	11,611,621	11,454,728
Special Supplemental Food Program (WIC)	1,366,617	1,423,757

VETERANS ADMINISTRATION

	1984 Act.	1985 Est.
Compensation	9,937,577	10,075,538
Pensions	3,878,998	3,848,421
Burial and Other	128,388	134,000
Medical Care (Operating)	7,875,034	8,445,248
Medical and Prosthetic Research	190,299	226,737
Medical Administration	65,576	68,849
General Operating	730,028	774,070

APPENDIX D

OTHER

APPENDIX D
PLANNING FOR A SYSTEM OF MENTAL HEALTH SERVICES

Generic Essential Service Functions	Settings and Sample Facilities		
	Natural (e.g. Home, Workplace, School, Police Stations, Public Places)	Supportive (e.g. Hospital Outpatient Clinic, Ambulatory Health Center, Mental Health Center, Halfway House, Supportive Living Arrangements, Sheltered Workshops, Specialized Long Term Care)	Protective (e.g. Hospital In-patient, Institutions, Skilled Nursing Facility)
A. Primary Prevention Services	-Prevention Physical Health Services -Public Information -Public Consultation and Instruction -Environmental Intervention	-Preventive Physical Health Services	-Preventive Physical Health Services
B. Consumer Identification, Diagnostic and Assessment Services	-Screening -Case Finding	-Screening	
C. Crisis Stabilization and Emergency Services	-Crisis Outreach -Temporary Foster Placement	-Crisis Support -Temporary Residence	-Crisis Care
D. Growth and Habilitation Services	-Outreach Growth Therapies -Outreach Social Skills Training -Consumer Education -Transitional Foster Placement -Outreach Vocational Training	-Growth Therapies -Social Skills Training -Daily Living Skills Training -Vocational Training -Sheltered Training -Recreation Training -Consumer Education -Transitional Residence	-Remotivational Care
E. Maintenance	-Outreach Maintenance Therapies -Unlimited Foster Placement	-Maintenance Therapies -Social Skills Maintenance -Daily Living Skills Maintenance -Unlimited Residence -Sheltered Work -Medication Management	-Sustaining Care
F. Case Management Services	-Case Management Assessment, Planning, Linking, Monitoring, and Advocacy Takes Place in All Settings		

Prepared by the Mental Health, Substance Abuse, and Developmental Disabilities Task Force of Suburban HSA   June 1982

APPENDIX D
FIFTY STATE RESPONSE SHOWS FIVE BASIC STATE-COUNTY GOVERNMENT MENTAL HEALTH SYSTEMS
June 1983

GROUP I

A. The state government is primary provider of mental health services. The counties share with the state in funding local mental health services.

8 states

ARKANSAS
HAWAII
LOUISIANA
WEST VIRGINIA
NEVADA
NEW MEXICO
NORTH DAKOTA
TEXAS

B. State government provides local mental health services primarily through private contractual arrangements. The counties share with the state in funding local mental health services.

9 states

ARIZONA
DELAWARE
INDIANA
MISSOURI
WYOMING
NEW HAMPSHIRE
NEW JERSEY
SOUTH DAKOTA
TENNESSEE

* *

GROUP II

A. The counties are primary providers of mental health services as sub-state authorities. Counties share with state in funding local mental health services.

9 states

CALIFORNIA
KANSAS
NEW YORK
GEORGIA
MARYLAND
PENNSYLVANIA
IOWA
MINNESOTA
UTAH

B. The primary provider of local mental health services are single or multi-county boards. The counties share with the state in funding local mental health services.

7 states

FLORIDA
MICHIGAN
WISCONSIN
MISSISSIPPI
MONTANA
NORTH CAROLINA
NEBRASKA

* *

GROUP III

A. The state government is primary provider of local mental health services and provides all public funding support.

6 states

ALASKA
CONNECTICUT
IDAHO
MAINE
OKLAHOMA
RHODE ISLAND

B. State government provides local mental health services primarily through private contractual agreements and the state government provides all public funding support.

2 states

MASSACHUSETTS
VERMONT

* *

GROUP IV

State and county governments provide mental health services primarily through public contractual arrangements and share in the funding of those local mental health services.

4 states

ALABAMA
KENTUCKY
ILLINOIS
COLORADO

* *

GROUP V

The state and county governments jointly provide mental health services, and the counties share with the states in funding local mental health services.

5 states

OREGON
WASHINGTON
SOUTH CAROLINA
OHIO
VIRGINIA

* *

This material has been developed by: NATIONAL ASSOCIATION OF STATE MENTAL HEALTH PROGRAM DIRECTORS, 1001 Third Street, S.W., Suite 115, Washington, D.C. 20024 - Phone (202) 554-7807. Study # 83-448

APPENDIX D
UPDATE ON STATUS OF STATE MENTAL HEALTH INSURANCE MANDATES

As of September 1983:

1. 39 states regulate either mental health, alcohol, or drug benefits in health insurance plans.
    - 13 states regulate benefits in all 3 areas

2. 36 states regulate alcohol benefits
    - 19 states have MBP laws (6 are MBP/MA)
    - 17 states have MA laws

3. 26 states regulate mental health benefits
    - 14 states have MBP laws (4 are MBP/MA)
    - 12 states have MA laws

4. 17 states regulate drug benefits
    - 9 states have MBP laws (3 are MBP/MA)
    - 8 states have MA laws

5. 1983 Activities in Mental Health Benefit Laws
    - MT, ME, and OR became the 12th, 13th, and 14th states to pass MBP laws
    - WA and AR passed MA laws

6. 1983 Activities in Alcohol and Drug Benefits Laws
    - MT and ME passed MBP laws for alcohol and drugs
    - OR passed MBP/MA laws for alcohol and MBP law for drugs
    - NV revised its MA laws for alcohol and drugs
    - NM passed MA law for alcohol

7. 38 states have freedom-of-choice laws for psychologists
    - AZ was added in 1983

8. 11 states have freedom-of-choice laws for social workers
    - MA, OK, KS, and ME were added in 1983

9. 2 states have freedom-of-choice laws for psychiatric nurses
    - ME was added in 1983

10. The practice of psychology is regulated in all 50 states, while the practice of social work is regulated in 29 states.

Code:
MBP = Mandated Benefits Package
MA = Mandated Availability
MBP/MA = Some benefits are mandated, while others are only required to be offered or may be refused.

SOURCE: John Amborse, Public Policy Department, National Mental Health Association, Arlington, VA. Information current as of September 1983.

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